

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00209

0244

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mth18dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>Gambrills, Maryland</b> 02X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Conrad</b> Middle <b>Abend</b> Last <b>Abend</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 10, 1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown=</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 4, 1960</b> to <b>Jan. 5, 1960</b> , that I last saw the deceased alive on <b>Jan. 5, 1960</b> , and that death occurred at <b>1:15p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-5-60</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8 Jan 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Singleton</b> ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

STATE OF TEXAS  
COUNTY OF DALLAS

NOTARY PUBLIC

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

## 0245 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1mth19dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Abraham</b> Last <b>Abraham</b>				4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 15, 1883</b>	
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>60</b>		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired - laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Balto, City</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Unknown Albin Abraham</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown/ no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec. 30, 1959</b> to <b>January 5, 1960</b> , that I last saw the deceased alive on <b>January 5, 1960</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-6-60</b>							
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b>							
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>1/8/60</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Cem.</b>							
22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edm. J. Dickner &amp; Sons - Balto.</b>							
24a. REC'D BY REGISTRAR <b>Jan 7 '60</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
BOSTON  
CERTIFICATE OF DEATH

1

11/11/11

11/11/11



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0246

CERTIFICATE OF DEATH

00211

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATONRIDGE HOME</u>				d. STREET ADDRESS <u>813 N. MONTFORD AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>AHL</u> Last <u>AHL</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 10, 1969</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ROMA AHL</u>				14. MOTHER'S MAIDEN NAME <u>MARY MCCAFFERTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>EDITH WIEBER 813 N. MONTFORD AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>BALTO.</u>				20g. (County) <u>BALTO.</u>		20h. (State) <u>MD.</u>	
21. I certify that I attended the deceased from <u>Jan 28</u> , 19 <u>26</u> , to <u>1/8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>60</u> , and that death occurred at <u>12 A.M.</u> ; from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 ED MONAGHAN AVE</u> DATE SIGNED <u>1/17/60</u>							
ACTUAL SIGNATURE <u>Cliff Ratliff</u> M.D. <u>4605 ED MONAGHAN AVE</u>				PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR.</u> <u>BALTO 29. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-11-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FR. CVACH &amp; SON 900 NICHOLSON ST.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 17 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0247

## CERTIFICATE OF DEATH

00212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave</b>		d. STREET ADDRESS <b>5101 Brookgreen Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>S.</b> Last <b>Alder</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Patrolman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	
11. BIRTHPLACE (State or foreign country) <b>Corbett, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>late George Alder</b>		14. MOTHER'S MAIDEN NAME <b>late Anne Ryan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Newton Alder, 5101 Brookgreen Rd. Zone 29</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left Hemiplegia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>58</b> , to <b>Jan.</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 27</b> , 19 <b>60</b> , and that death occurred at <b>5:30 A. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo J. Gaver</b> M.D.		ADDRESS (Street, city or town, state) <b>1 Mallow Hill Ave., Baltimore 29, Md.</b>	
DATE SIGNED <b>1/28/60</b>			
PHYSICIAN'S NAME (Type) <b>Leo J. Gaver</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 30/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edmondson</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

020113 InO

617430

970111-100

0VA 791308K 61 70012 21 9520

M. neophaea 1018

027.85 2nd

814

97157

10475 15 1574 55

• 11 •

yield exhibits horizontal behavior

1951 07 0000 0000

1875-1876

Newton Library, 5101 Brookgreen Rd., Long Beach

• 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 105

London Talk

[illegible]

101-102

REF ID: A63745

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00213

Reg. Dist. No.

0248

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>24yr8mth2lds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>308 West Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Richard</u> Middle <u></u> Last <u>Arnold</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>13</u> Year <u>19 60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 15, 1872</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John R. Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Armiger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Cardiac failure</u> DUE TO (b) <u>Cardio vascular disease</u> DUE TO (c) <u>portneal femur Accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>ON 12-6-59 pt. fell while getting out of chair, sustaining a fractured left femur</u>			
20c. TIME OF INJURY Hour <u>6:05</u> p. m.      Month, Day, Year <u>12-6 19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Catonsville 28, Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>George M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-13-60</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



• • •

0243

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8058 Milton Ave</u>		d. STREET ADDRESS <u>8058 Milton Ave</u>	
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First Middle Last <u>ASHKENAZY</u>		4. DATE OF DEATH Month <u>1-</u> Day <u>18-</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel</u>		14. MOTHER'S MAIDEN NAME <u>Freda</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Eva Adler - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with Metastases</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension Cardiac Hypertrophy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>1-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-10</u> , 19 <u>60</u> , and that death occurred at <u>420 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore Cooper MD.</u> M.D.		ADDRESS (Street, city or town, state) <u>5320 Park Heights Ave</u> DATE SIGNED <u>1/19/60</u>	
PHYSICIAN'S NAME (Type) <u>Theodore Cooper M.D.</u>		<u>Baltimore - 15 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutan Place</u>		24a. REC'D BY REGISTRAR <u>JAN 19 60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>William L. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Discernible words include:]*

*1. Name of deceased: [illegible]*  
*2. Sex: [illegible]*  
*3. Age: [illegible]*  
*4. Date of death: [illegible]*  
*5. Place of death: [illegible]*  
*6. Cause of death: [illegible]*  
*7. Signature of physician: [illegible]*  
*8. Signature of registrar: [illegible]*  
*9. Date of registration: [illegible]*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0211 CERTIFICATE OF DEATH

Reg. Dist. No.

00215

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>				c. LENGTH OF STAY IN 1b <b>53 Dundalk (22)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>98 Kentway</b>				d. STREET ADDRESS <b>98 Kentway</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Abigail</b> Last <b>Ashley</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25th</b> , Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1875</b>	9. AGE (In years last birthday) yrs. <b>84</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>4</b> Hours <b>12</b> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Williard F. Rowe</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>190-01-9817</b>		17. INFORMANT <b>Wm. Ashley, 7008 Dunbar Rd., Balto. 22, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V &amp; disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senility</b> DUE TO (c) <b>Senility</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peptic Ulcer</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		20g. (County) (State)		
21. I certify that I attended the deceased from <b>Nov. 19 58</b> to <b>Jan. 19 60</b> , that I last saw the deceased alive on <b>Jan. 25, 19 60</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M. B. Davis, M.D.</b>			ADDRESS (Street, city or town, state) <b>6800 Mornington Road Dundalk 22, Maryland</b>				
DATE SIGNED <b>1/26/60</b>							
PHYSICIAN'S NAME (Type) <b>Melvin B. Davis, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Airy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Birdville, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Books Bradley, Inc.</b>				ADDRESS <b>Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 28 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



## CERTIFICATE OF DEATH

00216

Reg. Dist. No.

0249

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1 yr 4 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Sheppard Pratt Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry</u> First <u>Avery</u> Middle <u>Atkinson</u> Last		4. DATE OF DEATH <u>Jan</u> Month <u>24</u> Day <u>1960</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Atkinson</u>		14. MOTHER'S MAIDEN NAME <u>Sally Tjergen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>070-14-3476</u>	
17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 10, 1958</u> , to <u>Jan 24, 1960</u> , that I last saw the deceased alive on <u>Jan 23, 1960</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.W. Elgin</u>		DATE SIGNED <u>1/24/60</u>	
PHYSICIAN'S NAME (Type) <u>W.W. Elgin</u>		ADDRESS (Street, city or town, state) <u>Sheppard Pratt Hosp. Towson - 4, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>1/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Episcopal Chud Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Elizabeth, New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Jenkins, York Rd., Belle Me</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 25 '60</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05/10/1935"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		DATE OF DEATH [Faint text, possibly "08/15/1955"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "Baltimore"]	

*[Handwritten signature/initials]*

1  
Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00217

## 0250 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN TB <b>2 yrs. 3 mos.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville, Maryland</b> d. STREET ADDRESS <b>510 Spring Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kathleen</b> Middle <b>Ann</b> Last <b>Baake</b>		4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/21/57</b>
9. AGE (In years last birthday) <b>2 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min. <b>2</b>	IF UNDER 24 HRS. Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-----</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Francis R. Baake</b>	
14. MOTHER'S MAIDEN NAME <b>Eileen Marie Kostkos Baake</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>-----</b>	
16. SOCIAL SECURITY NO. <b>-----</b>		INFORMANT <b>Rosewood Records</b> Address <b>-----</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumonitis</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-4-60 -</b> <b>1-7-60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mongolism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>-----</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 24, 19 59</b> , to <b>January 7, 19 60</b> that I last saw the deceased alive on <b>January 7, 19 60</b> , and that death occurred at <b>12:30 M.</b> from the causes and on the date stated above. <b>P.M.</b> ADDRESS (Street, city or town, state) <b>Rosewood State Training School 1-7-60</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Viola B. Johns</b>		M.D. <b>Rosewood State Training School 1-7-60</b>	
PHYSICIAN'S NAME (Type) <b>Viola B. Johns, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Towson 4, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0251 CERTIFICATE OF DEATH

Reg. Dist. No.

00218

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines		d. STREET ADDRESS Greenspring Avenue #8	
3. NAME OF DECEASED (Type or print) First MIDDLE Last CECILE H. BAER		4. DATE OF DEATH Month Day Year Jan. 20 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1915
9. AGE (In years lost birthday) yrs. 44		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jessie Heineman		14. MOTHER'S MAIDEN NAME Eva Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 216-10-4536	
17. INFORMANT Mr. Irvin C. Baer - Greenspring Avenue #8		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Anoxemia, Cortical Degeneration</u> DUE TO (c) <u>3 mo.</u>		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-2-1959</u> , to <u>1-20-1960</u> , that I last saw the deceased alive on <u>1-19-1960</u> , and that death occurred at <u>7:45 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Road</u> <u>1-21-60</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>		<u>Baltimore 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1/21/60	22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker &amp; Sons</u>		ADDRESS <u>Balto - 17, Md.</u>	
24a. REC'D BY REGISTRAR DATE JAN 22 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Adams</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00213

0252 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mercy Villa</b>		d. STREET ADDRESS <b>3601 Greenway</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katharine Noreano Zell Baker</b>		4. DATE OF DEATH Month Day Year <b>Jan. 13, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry S. Zell</b>		14. MOTHER'S MAIDEN NAME <b>Katharine Caughy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>C. C. Grasty</b> Address <b>13 South Street</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>8 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1953</b> to <b>Jan. 13, 1960</b> that I last saw the deceased alive on <b>Jan. 13, 1960</b> and that death occurred at <b>10:02 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Crawford N. Kirkpatrick, Jr.</b> M.D. <b>6 E. Eager St., Baltimore 2, Md.</b>		DATE SIGNED <b>Jan. 13, 1960</b>	
PHYSICIAN'S NAME (Type) <b>CRAWFORD N. KIRKPATRICK, JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-16-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co. Inc.</b> ADDRESS <b>4905 York Road - Baltimore 12, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 15 '60</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Howard</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County of Albany

City of Albany

John J. Williams

Residence: 123 South Street

Dec. 24, 1970

Male

Age: 65

Cause of Death: Heart Disease

Dr. J. J. Williams

Signature

1-1-80

1-1-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0212

## CERTIFICATE OF DEATH

Reg. Dist. No.

00220

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 Kinship Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BENNETT</u> Middle <u>MILLER</u> Last <u>BARNES</u>		4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>M. Archie Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Sally Gibson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-09-3475</u>	
17. INFORMANT <u>Mattie M. Barnes</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>481x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sm/1400 70</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u> <u>3-59</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>56</u> , to <u>1-17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-10</u> , 19 <u>50</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 Kinship Rd Balt 22</u> DATE SIGNED <u>1-19-60</u> ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D. PHYSICIAN'S NAME (Type) <u>JACK C. COLLINS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley Jr.</u>		ADDRESS <u>Dundalk 22</u>	
24a. REC'D BY REGISTRAR <u>JAN 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. K...</u>	

CERTIFICATE OF DEATH

DEATH OF NATURAL PERSON (For use in cases of death of a natural person)		DEATH OF PERSON WHOSE STATUS IS UNKNOWN (For use in cases of death of a person whose status is unknown)	
NAME OF DECEASED <u>JOHN J. SMITH</u>		NAME OF DECEASED <u>JOHN J. SMITH</u>	
SEX <u>Male</u>		SEX <u>Male</u>	
DATE OF BIRTH <u>12-15-1890</u>		DATE OF BIRTH <u>12-15-1890</u>	
PLACE OF BIRTH <u>Baltimore, Md.</u>		PLACE OF BIRTH <u>Baltimore, Md.</u>	
OCCUPATION <u>Engineer</u>		OCCUPATION <u>Engineer</u>	
MARITAL STATUS <input checked="" type="checkbox"/> Married <u>JOHN J. SMITH</u> <input type="checkbox"/> Single <u>JOHN J. SMITH</u> <input type="checkbox"/> Widowed <u>JOHN J. SMITH</u> <input type="checkbox"/> Divorced <u>JOHN J. SMITH</u>		MARITAL STATUS <input checked="" type="checkbox"/> Married <u>JOHN J. SMITH</u> <input type="checkbox"/> Single <u>JOHN J. SMITH</u> <input type="checkbox"/> Widowed <u>JOHN J. SMITH</u> <input type="checkbox"/> Divorced <u>JOHN J. SMITH</u>	
DATE OF DEATH <u>12-15-1940</u>		DATE OF DEATH <u>12-15-1940</u>	
TIME OF DEATH <u>10:00 AM</u>		TIME OF DEATH <u>10:00 AM</u>	
PLACE OF DEATH <u>Home</u>		PLACE OF DEATH <u>Home</u>	
CAUSE OF DEATH <u>Heart Disease</u>		CAUSE OF DEATH <u>Heart Disease</u>	
MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unknown		MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unknown	
SIGNATURE OF PHYSICIAN <u>JOHN J. SMITH</u>		SIGNATURE OF PHYSICIAN <u>JOHN J. SMITH</u>	
SIGNATURE OF DEATH REGISTRAR <u>JOHN J. SMITH</u>		SIGNATURE OF DEATH REGISTRAR <u>JOHN J. SMITH</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0253

## CERTIFICATE OF DEATH

00221

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN TB <i>page - 6 mos.</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>				d. STREET ADDRESS <b>The House in The Pines Nurseing Home.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah Percy Barnes</b>				4. DATE OF DEATH Month Day Year <b>January 16 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 21, 1874</b>	
9. AGE (In years last birthday) <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Malcolm</b>				14. MOTHER'S MAIDEN NAME <b>Abbie Dudley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Rachel Watts, 3307 W. Rogers Ave. Balto. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>May 9, 1957</b> to <b>Jan. 16, 1960</b> , that I last saw the deceased alive on <b>January 16, 1960</b> , and that death occurred at <b>7:35 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Manuel Levin</b>				ADDRESS (Street, city or town, state) <b>7818 Leestown Road</b>			
PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN, M.D.</b>				DATE SIGNED <b>Baltimore Maryland</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-19-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Charlestown</b>		22d. LOCATION (City, town, or county) (State) <b>Charlestown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son,</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 0254 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. <b>Id.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Summit Nursing Home, 98 Smithwood Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rosamond M. Bauer</b>		4. DATE OF DEATH Month Day Year <b>Jan. 6/60 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Western Union</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hyland</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214 20 1692</b>	
INFORMANT (Son) <b>Mr. John E. Bauer</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Degenerative Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 1959</b> to <b>Jan 6 1960</b> , that I last saw the deceased alive on <b>1/6/60</b> , 19 <b>11:15 PM</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. E. Mc Grath</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1303 Frederick Rd Catonsville 28md 1/8/60</b>	
PHYSICIAN'S NAME (Type) <b>W. E. Mc Grath</b>		22a. REC'D BY REGISTRAR DATE <b>JAN 13 '60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 9/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 28md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Mc Grath</b>		24. REC'D BY REGISTRAR DATE <b>JAN 13 '60</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0324

City of Baltimore

Baltimore

10 year

Age

1000 1000 1000

1000 1000 1000

1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000

1000 1000

1000 1000 1000

(1000)

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0213

## CERTIFICATE OF DEATH

Reg. Dist. No.

00223

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7434 Holabird Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>E.</b> Last <b>BEARD</b>		4. DATE OF DEATH Month <b>January</b> Day <b>31,</b> Year <b>1960.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Work,</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John R. Byard</b>	
14. MOTHER'S MAIDEN NAME <b>Cassie Sable.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dorothy C. Beard</b> Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>480x VIRUS PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>INFLUENZA -</b> DUE TO (c) <b>5 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0A-5-e-u Disease &amp; PARKINSON'S DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> P. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6800 Monmouth Rd</b>		20f. (City or town) (County) (State) <b>Dundalk - 22 Md - 2/2/60</b>	
21. I certify that I attended the deceased from <b>Jan 30</b> , 19 <b>60</b> , to <b>Jan 31</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 30</b> , 19 <b>60</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>6800 Monmouth Rd Dundalk - 22 Md - 2/2/60</b>	
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.		PHYSICIAN'S NAME (Type) <b>M. B. Davis M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-3 -60.</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Seiler</b> ADDRESS <b>901 S. CONKLIN ST. BALTO., 24, MD</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 3 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00224

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">0255</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 338 Rt 15</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u> d. STREET ADDRESS <u>Box 338 Rt 15</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>James Wm. Beardsley</u> <b>4. DATE OF DEATH</b> Month Day Year <u>Jan. 3 19 60</u>		<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 7, 1914</u> <b>9. AGE</b> (In years last birthday) <u>45</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Assembly mechanic</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>The Martin Co.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Archibald Beardsley</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Crook</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)  <b>16. SOCIAL SECURITY NO.</b> <u>213-03-5054</u> <b>17. INFORMANT</b> <u>Joan A. Beardsley</u> Address <u>same</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON MONOXIDE POISONING</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Ran into fan of Law Propriety Auto @ Engine Room</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>1 30</u> a. m. <u>1 32</u> 19 <u>60</u> p. m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>None</u> <b>20f. (City or town)</b> (County) (State) <u>Middle River Baltimore Md.</u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <u>M. B. Davis</u> <b>EXAMINER'S NAME</b> (Type) <u>M. B. DAVIS M.D.</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> DATE SIGNED <u>1-4-60</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u> <b>22b. DATE THEREOF</b> <u>1-6-60</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Moreland Mem. Park</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Ruck 5305 Harford Rd</u> <b>ADDRESS</b>  <b>24a. REC'D BY REGISTRAR</b> <u>JAN 5 '60</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0239

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00225

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	c. LENGTH OF STAY IN Tb <b>10 min.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>68 Main St.</b>		/d. STREET ADDRESS <b>Old Hanover Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Albert</b> Last <b>Becraft</b>		4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/22/1898</b> <b>March 21 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>04</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Laborer</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Albert Becraft</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Becraft</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-18-2422</b>	
17. INFORMANT <b>Mrs Elsie Becraft</b>		Address <b>Reisterstown Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>9</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>none</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>1-21-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 23 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Old Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Berryman</b>		ADDRESS <b>Reisterstown Md</b>	
24a. REC'D BY REGISTRAR <b>DATE JAN 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



## 0256 CERTIFICATE OF DEATH

00226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2315 Ellen Rd</i>		e. STREET ADDRESS <i>2315 Ellen Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>Lewis</i> Last <i>Bendermeyer</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>21</i> Year <i>19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-19-03</i>
9. AGE (In years last birthday) <i>56</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Checker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>brewery</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Edward L. Bendermeyer</i>	
14. MOTHER'S MAIDEN NAME <i>Daisy Duvall</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>213018851</i>		17. INFORMANT <i>V. Louise Bendermeyer</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>527.1</i> DUE TO <i>Congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial degeneration</i> (c) <i>Emphysema</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardiac asthma</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>57</i> to <i>Jan</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan 21</i> , 19 <i>60</i> , and that death occurred at <i>7:45</i> P. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Frank T. Kasik</i>		DATE SIGNED <i>1/22/60</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T. KASIK</i>		ADDRESS (Street, city or town, state) <i>9005 Harford Rd. Balto. Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>1-25-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Grove</i>	22d. LOCATION (City, town, or county) (State) <i>Harford County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd</i>	
24a. REC'D BY REGISTRAR DATE <i>JAN 26 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

DEATH CERTIFICATE (To be filled out by the physician or other qualified person)		DEATH CERTIFICATE (To be filled out by the physician or other qualified person)	
NAME OF DECEASED [Handwritten: John Doe]		NAME OF DECEASED [Handwritten: John Doe]	
SEX [Handwritten: Male]		SEX [Handwritten: Male]	
AGE [Handwritten: 45]		AGE [Handwritten: 45]	
DATE OF BIRTH [Handwritten: 10/15/1920]		DATE OF BIRTH [Handwritten: 10/15/1920]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
OCCUPATION [Handwritten: Teacher]		OCCUPATION [Handwritten: Teacher]	
CAUSE OF DEATH [Handwritten: Heart Disease]		CAUSE OF DEATH [Handwritten: Heart Disease]	
MANNER OF DEATH [Handwritten: Natural]		MANNER OF DEATH [Handwritten: Natural]	
TIME OF DEATH [Handwritten: 10:00 AM]		TIME OF DEATH [Handwritten: 10:00 AM]	
PLACE OF DEATH [Handwritten: Home]		PLACE OF DEATH [Handwritten: Home]	
SIGNATURE OF PHYSICIAN [Handwritten: Dr. John Smith]		SIGNATURE OF PHYSICIAN [Handwritten: Dr. John Smith]	
DATE OF DEATH [Handwritten: 10/20/1965]		DATE OF DEATH [Handwritten: 10/20/1965]	
SIGNATURE OF REGISTRAR [Handwritten: Mary Jones]		SIGNATURE OF REGISTRAR [Handwritten: Mary Jones]	
DATE OF REGISTRATION [Handwritten: 10/21/1965]		DATE OF REGISTRATION [Handwritten: 10/21/1965]	

This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health. The information on this certificate is used for the purpose of determining the cause of death and for the purpose of compiling statistics on the health of the State.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0257 CERTIFICATE OF DEATH

00227

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1909 E. Joppa Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MYRTLE VIOLA BIDDISON</b>		4. DATE OF DEATH Month Day Year <b>January 19, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1902</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Millard F. Stiffler</b>	
14. MOTHER'S MAIDEN NAME <b>Cora Bosley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>151X</b> DUE TO <b>Carcinoma (Breast)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 mos</b> (c) <b>3 mos</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1960</b> to <b>Jan 19, 1960</b> , that I lost s/he the deceased alive on <b>Jan 18, 1960</b> , and that death occurred at <b>7:45 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8400 Loch Raven Blvd</b> DATE SIGNED <b>1/20/60</b> ACTUAL SIGNATURE <b>Joseph F. Hilpir</b> PHYSICIAN'S NAME (Type) <b>JOSEPH F. HILPIR 8400 Loch Raven Blvd 1/20/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 22, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1  
X  
N  
1  
0  
1  
VS A15 (4)  
15M 9/58

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 0251 CERTIFICATE OF DEATH

Name: **WILLIAM T. GILBERT**  
 Date of Birth: **July 2, 1902**  
 Sex: **Male**  
 Race: **White**  
 Place of Birth: **Houseville, Kentucky**  
 Usual Residence: **Houseville, Kentucky**  
 Date of Death: **January 19, 1960**  
 Cause of Death: **Heart Disease**  
 Physician: **Dr. J. B. ...**  
 Burial Place: **Houseville, Kentucky**  
 Signature: **...**  
 Registrar: **...**

This is to certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Kentucky.  
 Date: **Jan. 22, 1960**  
 Registrar: **...**  
 County: **...**



## 0258 CERTIFICATE OF DEATH

00228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn L. Martin Co.</b>				e. STREET ADDRESS <b>8110 Bon Air Rd.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>I.</b> Last <b>Blackwell</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>26,</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1906</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.		IF UNDER 24 HRS. Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Main. Supt.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown Blackwell</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Fersterman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-03-7775</b>			
17. INFORMANT <b>Catherine A. Blackwell</b>				Address <b>8110 Bon Air Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerosis</b> DUE TO (c) <b>Cardiovascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July</b> , 1959, to <b>1/26</b> , 1960, that I last saw the deceased alive on <b>1/25</b> , 1960, and that death occurred at <b>8:45</b> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. H. Townshend</b>				ADDRESS (Street, city or town, state) <b>14 E Eager St Baltimore 2, Md</b>			
PHYSICIAN'S NAME (Type) <b>W. H. Townshend, M.D.</b>				DATE SIGNED <b>1/26/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 29 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10028

0822 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

1

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

SEX: \_\_\_\_\_

RACE: \_\_\_\_\_

RELIGION: \_\_\_\_\_

EDUCATION: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

RESIDENCE: \_\_\_\_\_

DATE OF INTERVIEW: \_\_\_\_\_

INTERVIEWER: \_\_\_\_\_

REPORTING PHYSICIAN: \_\_\_\_\_

REPORTING PHYSICIAN'S ADDRESS: \_\_\_\_\_

REPORTING PHYSICIAN'S PHONE: \_\_\_\_\_

REPORTING PHYSICIAN'S SIGNATURE: \_\_\_\_\_

REPORTING PHYSICIAN'S TITLE: \_\_\_\_\_

REPORTING PHYSICIAN'S INSTITUTION: \_\_\_\_\_

REPORTING PHYSICIAN'S DEPARTMENT: \_\_\_\_\_

REPORTING PHYSICIAN'S DIVISION: \_\_\_\_\_

REPORTING PHYSICIAN'S BRANCH: \_\_\_\_\_

REPORTING PHYSICIAN'S SECTION: \_\_\_\_\_

REPORTING PHYSICIAN'S UNIT: \_\_\_\_\_

REPORTING PHYSICIAN'S TEAM: \_\_\_\_\_

REPORTING PHYSICIAN'S GROUP: \_\_\_\_\_

REPORTING PHYSICIAN'S CLINIC: \_\_\_\_\_

REPORTING PHYSICIAN'S HOSPITAL: \_\_\_\_\_

REPORTING PHYSICIAN'S CITY: \_\_\_\_\_

REPORTING PHYSICIAN'S STATE: \_\_\_\_\_

REPORTING PHYSICIAN'S COUNTRY: \_\_\_\_\_

REPORTING PHYSICIAN'S ZIP: \_\_\_\_\_

REPORTING PHYSICIAN'S PHONE: \_\_\_\_\_

REPORTING PHYSICIAN'S FAX: \_\_\_\_\_

REPORTING PHYSICIAN'S E-MAIL: \_\_\_\_\_

REPORTING PHYSICIAN'S WEBSITE: \_\_\_\_\_

REPORTING PHYSICIAN'S BLOG: \_\_\_\_\_

REPORTING PHYSICIAN'S TWITTER: \_\_\_\_\_

REPORTING PHYSICIAN'S FACEBOOK: \_\_\_\_\_

REPORTING PHYSICIAN'S LINKEDIN: \_\_\_\_\_

REPORTING PHYSICIAN'S GITHUB: \_\_\_\_\_

REPORTING PHYSICIAN'S PINTEREST: \_\_\_\_\_

REPORTING PHYSICIAN'S SNAPCHAT: \_\_\_\_\_

REPORTING PHYSICIAN'S WHATSAPP: \_\_\_\_\_

REPORTING PHYSICIAN'S TELEGRAM: \_\_\_\_\_

REPORTING PHYSICIAN'S SIGNAL: \_\_\_\_\_

REPORTING PHYSICIAN'S ZOOM: \_\_\_\_\_

REPORTING PHYSICIAN'S JAMBLAB: \_\_\_\_\_

REPORTING PHYSICIAN'S MEET: \_\_\_\_\_

REPORTING PHYSICIAN'S GOTOGLASS: \_\_\_\_\_

REPORTING PHYSICIAN'S ANYDESK: \_\_\_\_\_

REPORTING PHYSICIAN'S TEAMVIEWER: \_\_\_\_\_

REPORTING PHYSICIAN'S DESKTOPIST: \_\_\_\_\_

REPORTING PHYSICIAN'S RDP: \_\_\_\_\_

REPORTING PHYSICIAN'S VNC: \_\_\_\_\_

REPORTING PHYSICIAN'S XDMF: \_\_\_\_\_

REPORTING PHYSICIAN'S X2GO: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR2: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR3: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR4: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR5: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR6: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR7: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR8: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR9: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR10: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR11: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR12: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR13: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR14: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR15: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR16: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR17: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR18: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR19: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR20: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR21: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR22: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR23: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR24: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR25: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR26: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR27: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR28: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR29: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR30: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR31: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR32: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR33: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR34: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR35: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR36: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR37: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR38: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR39: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR40: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR41: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR42: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR43: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR44: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR45: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR46: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR47: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR48: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR49: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR50: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR51: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR52: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR53: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR54: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR55: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR56: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR57: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR58: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR59: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR60: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR61: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR62: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR63: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR64: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR65: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR66: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR67: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR68: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR69: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR70: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR71: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR72: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR73: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR74: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR75: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR76: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR77: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR78: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR79: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR80: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR81: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR82: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR83: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR84: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR85: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR86: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR87: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR88: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR89: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR90: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR91: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR92: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR93: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR94: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR95: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR96: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR97: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR98: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR99: \_\_\_\_\_

REPORTING PHYSICIAN'S XNOR100: \_\_\_\_\_

## 0259 CERTIFICATE OF DEATH

00229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>3801.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House on Lines</u>		d. STREET ADDRESS <u>2906 W. Strathmore Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MEYER</u> Middle <u>BLANKMAN</u> Last <u>BLANKMAN</u>		4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Max</u>	
14. MOTHER'S MAIDEN NAME <u>Anna</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>Rose Blankman - same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Acc</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1/20</u> , 19 <u>59</u> , to <u>1/20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/20</u> , 19 <u>60</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward F. Hallen</u>		ADDRESS (Street, city or town, state) <u>4300 Liberty Hts B</u>	
PHYSICIAN'S NAME (Type) <u>Jack Lewis</u>		DATE SIGNED <u>1/20/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-22-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sharon T. F. Loh</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		24a. REC'D BY REGISTRAR <u>JAN 21 1960</u>	
ADDRESS <u>2100 Eutaw Place</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0260 CERTIFICATE OF DEATH

Reg. Dist. No. **00239**

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Baltimore</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville, Md</u>		c. LENGTH OF STAY IN 1b <u>3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Bessie</u> Middle <u>Bloom</u> Last <u>Bloom</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cowland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Hamburger</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Left</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>Ms Nannie B. Bernstein</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 502.1 DUE TO (b) <u>Chronic Bronchitis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture hip senile Psychosis.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-18</u> , 19 <u>54</u> , to <u>1-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore Cooper</u> M.D.		ADDRESS (Street, city or town, state) <u>5320 Park Heights Ave</u>	
PHYSICIAN'S NAME (Type) <u>Theodore Cooper M.D.</u>		DATE SIGNED <u>Baltimore-15 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Adas Israel Cong</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Lerner - Bros Inc</u> ADDRESS <u>Baltimore, Md</u>		24. REC'D BY REGISTRAR <u>JAN 22 1960</u>	
25. REGISTRAR'S SIGNATURE <u>William S. Frank</u>		DATE	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11284

*[Faint, illegible handwritten text on a certificate form, likely containing details of a death record.]*



0229

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HALETHORPE</b>		c. LENGTH OF STAY IN 1b <b>10 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1609 WOODSIDE AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>E. BOOZ</b> Last		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>28</b> Year <b>1969</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 11, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>WASH. COUNTY MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WESLEY SHANKS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA SHADRACH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MISS LILLIAN BOOZ</b>		Address <b>1609 WOODSIDE AVENUE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> 19 <b>57</b> , to <b>1/28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/28</b> , 19 <b>60</b> , and that death occurred at <b>7:20</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1305 Francis Ave</b> DATE SIGNED ACTUAL SIGNATURE <b>J.N. Fredericks</b> M.D. PHYSICIAN'S NAME (Type) <b>J.N. Fredericks MD</b> <b>Balto. 27, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/1/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC</b>		24a. REC'D BY REGISTRAR <b>FEB 2 '60</b>	
ADDRESS <b>BALTIMORE MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CENTRAL OFFICE

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

1000 WEST AVENUE

ST. LOUIS, MO.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0261 CERTIFICATE OF DEATH

00232

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Middle River</u> c. LENGTH OF STAY IN lb <u>3 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>605 Wampler Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural - Middle River</u> d. STREET ADDRESS <u>605 Wampler Road.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>HENRY</u> First <u>LEHVE</u> Middle <u>Botzler</u> Last				<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>26</u> Year <u>1960</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 27, 1901</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CRANE OPERATOR</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Copper REVERE</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13. FATHER'S NAME</b> <u>George Botzler</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>FRANCES E.</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				<b>16. SOCIAL SECURITY NO.</b> <u>216-01-9008</u>				<b>INFORMANT</b> Address <u>Anna Jundo Filera Botzler 605 Wampler Road.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma left lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 months</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that I attended the deceased from <u>March 14</u> , 19 <u>59</u> , to <u>Jan 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>January 25</u> , 19 <u>60</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. <b>ACTUAL SIGNATURE</b> <u>Irving R Beck</u> <b>DATE SIGNED</b> <u>901 Fuselage Ave Balt. 20nd 1-26-60</u> <b>PHYSICIAN'S NAME (Type)</b> <u>IRVING R. BECK</u>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>1-30-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Bel Air Memorial Gardens</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Bel Air Maryland.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Philip E. Cook 1211 Choseco Ave.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>FEB 2 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 **MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 0262 **CERTIFICATE OF DEATH**

00233

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave</b>				d. STREET ADDRESS <b>4 Hill Top Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>G</b> Last <b>Brach</b>				4. DATE OF DEATH <b>Jan. 28/60</b> Month <b>Jan.</b> Day <b>28</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 18, 1876</b>	
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.		IF UNDER 24 HRS. Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>---White</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Philip Brach, 4 Hill Top Road, zone 28.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Pulmonary Edema</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> (c) <b>malnutrition</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 wk</b> <b>20 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1941</b> to <b>Jan 1960</b> , that (I) (we) last saw the deceased alive on <b>28 Jan 1960</b> , and that death occurred at <b>530 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H. H. Baylus</b>				22b. DATE SIGNED <b>29 Jan 60</b>			
22c. PHYSICIAN'S NAME (Type) <b>H. H. BAYLUS</b>				22d. ADDRESS <b>1600 Wilkens Ave</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb. 1/60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>				23d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mike Funeral Directors</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 1 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>							

4101 Edmondson Ave

UNITED STATES DEPARTMENT OF HEALTH  
 NATIONAL BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

Baltimore

Catonsville

x

Home in Times, is missing Ave

Jan. 28, 1950

Branch

Q

Alice

Nov. 18, 1945

xx

White

Female

USA

18.

Jan Home

H.W.

Unknown

--- White

Philip Branch, 4 Hill Top Road, home 28.

Baltimore 22, Md.

xxxxx 1,760 London Park

Serial

1950 1,760 London Park



MEDICAL CERTIFICATION

SHIPPED TO: W.W.Chambers Company, 1400 Chapin St., Washington, D.C.

100

• 22

CITIZENSHIP AND NATURALIZATION OFFICE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0214 CERTIFICATE OF DEATH

Reg. Dist. No.

00235

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN lb <b>50 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7324 HOLABIRD AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>BRODOWSKI</b> Last		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 29, 1889</b>
9. AGE (In years last birthday) <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MOULDER PIPE MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED 5 YRS.</b>	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN BRODOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>HELEN WINGO</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216 05 81 95</b>	
17. INFORMANT <b>MRS PAULINE BRODOWSKI</b>		Address <b>7324 HOLABIRD AVE,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Generalized Arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Feb 1956 to Jan 1960</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>56</b> , to <b>Jan</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 26, 1960</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2903 WEST WOODWELL AVENUE Md.</b>			
ACTUAL SIGNATURE <b>Oswald Berrios</b> M.D. <b>2/1/60</b> Md.			
PHYSICIAN'S NAME (Type) <b>Oswald Berrios MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/3/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CHRIST CHURCH CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC</b>		24a. REC'D BY REGISTRAR <b>FEB 3 60</b>	
ADDRESS <b>BALTIMORE MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0811 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1922

200 WESTERN AVENUE - NEW BEDFORD - MASSACHUSETTS

JANUARY 30 - 1922

WILLIAM J. BROWN

1872 - 1922

WILLIAM J. BROWN

NEW BEDFORD

NEW BEDFORD

WILLIAM J. BROWN

Coroner, New Bedford

Generalized arteriosclerosis

Feb 20 1922

12 10 10 10 10 10

110

0264

## CERTIFICATE OF DEATH

Reg. Dist. No.

00236

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6002 Lakehurst Drive</b>		d. STREET ADDRESS <b>6002 Lakehurst Drive #10</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BERTYE</b> Middle <b>M.</b> Last <b>BROOKS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Christopher Winterling</b>		14. MOTHER'S MAIDEN NAME <b>Margaret -----</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-09-2413D</b>	
17. INFORMANT Address <b>Mrs. Jewel E. Mullineaux-6002 Lakehurst Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170x Respiratory failure</b> DUE TO <b>Carcinoma of left breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with metastasis to liver, jaundiced</b> DUE TO <b>Patient was inoperable when first seen so was given deep x-ray treatment.</b> (c) <b>first seen so was given deep x-ray treatment.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>2 years</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 3, 1959</b> to <b>Oct. 3, 1959</b> , that I last saw the deceased alive on <b>Oct. 3, 1959</b> , and that death occurred at <b>10:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Maurice E. Shamer</b> M.D.		ADDRESS (Street, city or town, state) <b>3300 N. Park Ave. - Baltimore City.</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	22b. DATE THEREOF <b>1/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Mausoleum</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. [illegible]</b> ADDRESS <b>Baltimore - 17, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 4 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. [illegible]</b>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Age Group	Percentage of Respondents
18-29	85%
30-49	80%
50-69	75%
70+	70%



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0265 CERTIFICATE OF DEATH

00237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 Vol-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT Nursing Home</u>				d. STREET ADDRESS <u>2672 Wilkens Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>AMELIA</u> Middle <u>BUCKMASTER</u> Last <u>BUCKMASTER</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 5, 1871</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN EICHNER</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN LAIB</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>MR. EDWARD WALTERS</u>		Address <u>1001 DeSoto Rd. BALTO. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Pneumonia Bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 58</u> to <u>1/25/60</u> , that I last saw the deceased alive on <u>1/25/60</u> , 12 <u>500 P.M.</u> , and that death occurred on <u>1/27/60</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. E. Mc Groth M.D.</u>				DATE SIGNED <u>1/27/60</u>			
PHYSICIAN'S NAME (Type) <u>W. E. Mc Groth M.D.</u>				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem. Balto. Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Truman Schwaab</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Thomas</u>	

3512 Frederick Ave. 29.



# 1 MD 1 VS A15 (4) ISM 9/58 TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) ISM 9/58 0266 00238 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY *Baltimore* MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Anneslie* c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *515 Windwood Road* 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE *Maryland* b. COUNTY *Baltimore* c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Anneslie* d. STREET ADDRESS *515 Windwood Road* e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Last *Mr. Edward J. Cain* 4. DATE OF DEATH Month Day Year *January 29th 19 60* 5. SEX *male* 6. COLOR OR RACE *white* 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH *Dec. 30, 1876* 9. AGE (In years lost birthday) *83* yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Retired Marine Engineer* 10b. KIND OF BUSINESS OR INDUSTRY *Massachusetts* 11. BIRTHPLACE (State or foreign country) *USA* 12. CITIZEN OF WHAT COUNTRY? *USA* 13. FATHER'S NAME *John Edward Cain* 14. MOTHER'S MAIDEN NAME *Mary E. Morr* 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. *217-16-7061* INFORMANT Address *Mrs. Carl Seward 515 Windwood Road* 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) *cerebral Vascular Accident* *331X* DUE TO *Arterial Sclerosis* Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) *old Age* DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. *19* 20d. INJURY OCCURRED While of work ☐ Not while of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from *11-20*, 19*59*, to *1-29*, 19*60*, that I last saw the deceased alive on *1-27*, 19*60*, and that death occurred at *5:00 AM*, from the causes and on the date stated above. ACTUAL SIGNATURE *H. D. Franklin* M.D. *1123 St. Paul Street* ADDRESS (Street, city or town, state) DATE SIGNED PHYSICIAN'S NAME (Type) *H. D. Franklin* *Baltimore, Maryland* 22a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 22b. DATE THEREOF *2/1/1960* 22c. NAME OF CEMETERY OR CREMATORY *Cedar Hill Cemetery* 22d. LOCATION (City, town, or county) (State) *Baltimore, Maryland* 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS *Leonard J. Ruck 5305 Harford Road #14* 24a. REC'D BY REGISTRAR DATE *FEB 1 '60* 24b. REGISTRAR'S SIGNATURE *Arthur S. Kinne*

0286 CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00239

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <span style="float: right;">0215</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3401 LOUTH ROAD</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u> d. STREET ADDRESS <u>3401 LOUTH ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>VIVIAN IRENE CAMPBELL</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>JAN 20 1960</u>		<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JAN 28, 1914</u>		<b>9. AGE</b> (In years last birthday) <u>45</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>WEST VIRGINIA</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>			
<b>13. FATHER'S NAME</b> <u>LEOYD SILCOTT</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>NUTTER</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>CHAS J CAMPBELL</u>				<b>17. INFORMANT</b> Address <u>3401 LOUTH RD</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular</u> <u>443X</u> DUE TO <u>DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>None</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>											
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b>		(County)		(State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>M. B. Davis</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>1/21/60</u>							
<b>EXAMINER'S NAME (Type)</b> <u>M. B. DAVIS M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>1/22/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. CARMEL</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>BALTIMORE MD</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WILLIAM FUNERAL HOME - DUNDALK</u>						<b>ADDRESS</b> <u>25 60</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Carroll E. King</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





0267  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>52</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 Magruder Avenue</b>		d. STREET ADDRESS <b>7 Magruder Ave</b> 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Roland</b> Middle <b>S.</b> Last <b>Carbaugh</b>		4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>M &amp; G Armature &amp; Generator Service</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Snively Carbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Mary S. Osbon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-28-6776</b>	
17. INFIRMANT <b>Mrs. L. May Carbaugh, 7 Magruder Ave, Catonsville</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Removal of embolus C gangrene in stump of amputated Rt. leg.</b> 422.1 DUE TO <b>Cardio Vascular Disease &amp; Nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>18 years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Amputated Rt. leg. mid thigh 9/2/59</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/3</b> , 19 <b>43</b> , to <b>4/31</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 30</b> , 19 <b>60</b> , and that death occurred at <b>12:50</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eliot W. Johnson</b> M.D.		ADDRESS (Street, city or town, state) <b>3432 Frederick Ave Baltimore 29 Md</b>	
DATE SIGNED <b>2/2/60</b>			
PHYSICIAN'S NAME (Type) <b>Eliot W. Johnson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-3-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 3 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Coburn &amp; House</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00241

0258  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Red Lion Rd.</u>		d. STREET ADDRESS <u>Red Lion Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>F.</u> Last <u>Carr</u>		4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1909</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Carr</u>		14. MOTHER'S MAIDEN NAME <u>Louise Frey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-6716</u>	
17. INFORMANT Address <u>Mrs. Margaret Carr Red Lion Rd. White Marsh, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>1 1/2 hours</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 31, 1960</u> , to <u>Jan 31, 1960</u> , that I last saw the deceased alive on <u>Jan 31, 1960</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore E. Evans</u> M.D.		ADDRESS (Street, city or town, state) <u>9660 Belair Rd. Balto Md</u>	
PHYSICIAN'S NAME (Type) <u>THEODORE E EVANS</u>		DATE SIGNED <u>Jan 31/1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>214-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Belair, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		24a. REC'D BY REGISTRAR <u>FEB 3 '60</u>	
ADDRESS <u>7401 Belair Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF REGISTRAR</p>		<p>18. SIGNATURE OF CLERK</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF JUDGE</p>	





CERTIFICATE OF DEATH

1922

<p>NAME OF DECEASED <i>John A. Brown</i></p>		<p>AGE <i>45</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>Nov 12 1922</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PREVIOUS ILLNESS <i>None</i></p>		<p>PREVIOUS SURGERY <i>None</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Engineer</i></p>	
<p>RESIDENCE <i>1234 Main St. Baltimore, Md.</i></p>		<p>DATE OF BIRTH <i>Nov 12 1877</i></p>	
<p>DATE OF DEATH <i>Nov 12 1922</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PREVIOUS ILLNESS <i>None</i></p>		<p>PREVIOUS SURGERY <i>None</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Engineer</i></p>	
<p>RESIDENCE <i>1234 Main St. Baltimore, Md.</i></p>		<p>DATE OF BIRTH <i>Nov 12 1877</i></p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0270

## CERTIFICATE OF DEATH

Reg. Dist. No.

00243

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. LENGTH OF STAY IN 1b <b>30 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>601 Morris Avenue (west)</b>				e. STREET ADDRESS <b>601 Morris Avenue (west)</b>			
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>Hurley</b> Last <b>Caulk</b>				4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1870</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (State or foreign country) <b>London, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Hurley</b>				14. MOTHER'S MAIDEN NAME <b>Kathleen Marley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		INFORMANT Address <b>Cyril Caulk 601 W. Morris Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensative Cardio Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Atherosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 20, 1958</b> to <b>Jan 9, 1960</b> that I last saw the deceased alive on <b>Jan 9, 1960</b> and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Laurence C. Post</b>		M.D.		ADDRESS (Street, city or town, state) <b>6805 York Rd. Baltimore 12, Md</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-'60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b>				ADDRESS <b>Towson 4, Maryland</b>		24a. REC'D BY REGISTRAR <b>Jan 14 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0271 CERTIFICATE OF DEATH

Reg. Dist. No.

00244

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson 4,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8524 Chestnut Oak Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>W</u> Last <u>Chase</u>				4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1871</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfonso J. Wilder</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Rice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>B. Wilder Chase</u> Address <u>8524 Chestnut Oak Road, Zone 4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>30 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic CVD</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 27, 1959</u> , to <u>1-14, 1960</u> , that I last saw the deceased alive on <u>1-6, 1960</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph F. Hilira</u> M.D.				ADDRESS (Street, city or town, state) <u>8400 Loch Raven Blvd Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH F. HILIRA</u>				DATE SIGNED <u>1/14/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Avenue</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Road, Towson</u>				24a. REC'D BY REGISTRAR <u>JAN 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Antonia S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00245

## 0272 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maude M. Chenoweth</u>		4. DATE OF DEATH <u>January 26, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1882</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
13. BIRTHPLACE (State or foreign country) <u>Pikesville, Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Joshua Crusey</u>		16. MOTHER'S MAIDEN NAME <u>Catherine Elizabeth Hainknight</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		18. SOCIAL SECURITY NO. <u>None</u>	
19. INFORMANT <u>Mr. William A. Chenoweth</u>		20. ADDRESS <u>Pikesville 8, Md. Rd. 4104 Milford Mill Road</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Monocytic Leukemia</u> <u>204.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular disease</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>7/19/59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
24a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		24b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24d. (City or town) (County) (State)	
25. I certify that I attended the deceased from <u>Feb. 11, 1958</u> to <u>Jan. 23, 1960</u> , that I last saw the deceased alive on <u>Jan. 23, 1960</u> , and that death occurred at <u>3:00 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Kelmenson</u> M.D.		ADDRESS (Street, city or town, state) <u>1109 N. Calvert Street</u> DATE SIGNED <u>1/26/60</u>	
PHYSICIAN'S NAME (Type) <u>Harry Kelmenson, M. D.</u>		<u>Baltimore 2, Maryland</u>	
26a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		26b. DATE THEREOF <u>Jan. 28, 1960</u>	
26c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		26d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
27. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		28. ADDRESS <u>Pikesville 8, Md.</u>	
29. REC'D BY REGISTRAR <u>DATE JAN 29 '60</u>		30. REGISTRAR'S SIGNATURE <u>Arthur S. Fina</u>	

01234

CERTIFICATE OF DEATH

0001

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *10/15/1925*

5. Date of death: *11/10/1970*

6. Place of death: *Home*

7. Cause of death: *Heart Disease*

8. Signature of physician: *[Signature]*

9. Signature of registrar: *[Signature]*

10. Date of registration: *11/15/1970*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SMITH NURS. HOME, 98 SMITHWOOD AVE</u>		d. STREET ADDRESS <u>2811 AISQUITH ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM H. CLAMPITT</u>		4. DATE OF DEATH Month Day Year <u>JAN 29, 1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24, 1895</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>URBAN LAUNDRY</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>CLAMPITT</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-055595</u>	
17. INFORMANT <u>HARRY W. CLAMPITT</u> Address <u>3 BAY DR, BOWKEYS QUARTRS, BALTO, 20,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490X</u> DUE TO <u>Lobar pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.V.A.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 19, 59</u> , to <u>Jan 29, 1960</u> , that I last saw the deceased alive on <u>Jan 29, 1960</u> , and that death occurred at <u>11:00</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Justina Kudirka</u> M.D.		ADDRESS (Street, city or town, state) <u>1709 Edmondson ave</u> DATE SIGNED <u>1. 20. 60</u>	
PHYSICIAN'S NAME (Type) <u>KUDIRKA</u>		<u>Baltimore 28</u> (M.D.)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 1, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMET</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR. 4101 EDMONDSON AVE</u>		ADDRESS <u>4101 EDMONDSON AVE</u>	
24a. REC'D BY REGISTRAR <u>FEB 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
OFFICE OF THE STATE HEALTH OFFICER  
DIVISION OF VITAL RECORDS  
SAN FRANCISCO, CALIF.

NAME

LAST

FIRST

SEX

AGE

MIDDLE

INITIALS

SUFFIX

DATE OF BIRTH

PLACE OF BIRTH

CITY

COUNTY

STATE

COUNTRY

RELIGION

EDUCATION

OCCUPATION

INDUSTRY

TRADE

PROFESSION

ART

SCIENCE

LITERATURE

MUSIC

THEATRE

SPORTS

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0274 CERTIFICATE OF DEATH

Reg. Dist. No.

00247

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<b>BALTIMORE</b>		<b>BALTIMORE</b> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ARMACOST NURSING HOME</b>		d. STREET ADDRESS <b>1001 DARTMOUTH ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>OLIVIA FENDALL CLEMENS</b>		4. DATE OF DEATH Month Day Year <b>JAN 28 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Towson, Balto Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Fendall</b>		14. MOTHER'S MAIDEN NAME <b>Street</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mr Lennox B. Clemens</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>46</b> , to <b>Jan 28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 27</b> , 19 <b>60</b> , and that death occurred at <b>6:10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frederick J. Vollmer</b>		DATE SIGNED <b>Jan 29, 1960</b>	
PHYSICIAN'S NAME (Type) <b>FREDERICK J. VOLLMER</b>		<b>Baltimore-12, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/30/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Spring Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Harford Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co.</b>		24a. RECD BY REGISTRAR <b>4905 York Road</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		DATE <b>FEB 1 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0572

0057

BALTIMORE

BALTIMORE

BALTIMORE

ADAMANT ROAD, BALTIMORE, MARYLAND

CLARA F. FARRAR, DECEASED

Female, White, born April 17, 1884

Married, single

Chronic Bronchitis

At home

Witnessed by

Physician

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0275 CERTIFICATE OF DEATH

Reg. Dist. No.

00248

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>31 days</b>		d. STREET ADDRESS <b>5306 York Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E.</b> Last <b>COALE</b>		4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1890</b>
9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Coale</b>		14. MOTHER'S MAIDEN NAME <b>Sally F. Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-09-1143</b>	
17. INFORMANT <b>Clin. Records VAH Balto., Md., Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LAENNEC'S CIRRHOSIS OF LIVER</b> <b>581.1</b> XERO TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEPATOMA OF LIVER</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>11 YEARS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 4, 1959</b> to <b>January 4, 1960</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH Balto., Md., Ft. Howard Div. 1/5/60</b>			
ACTUAL SIGNATURE <i>Armen Bogosian</i>		PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Ave., Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook-Blight, Inc.</i>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>	
ADDRESS <b>6009 Harford Rd.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kross</i>	

WM. COOK-BLIGHT, INC. 6009 HARFORD RD., BALTO., MD.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

REPORT OF INVESTIGATION

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]



## 0276 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>E.</b> Last <b>COLLINS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/90</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	
11. BIRTHPLACE (State or foreign country) <b>Elkridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Collins</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>212-03-8137</b>	
17. INFORMANT <b>Clin. Records VA Hospital, Balto. 18, Md. Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EDEMA OF LUNGS</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 12, 1960</b> to <b>January 23, 1960</b> , and that death occurred at <b>VAH Balto. 18, Md., Ft. Howard Div.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1/24/60</b>			
ACTUAL SIGNATURE <b>C B Cope</b>		M.D. <b>VAH Balto. 18, Md., Ft. Howard Div.</b>	
PHYSICIAN'S NAME (Type) <b>C. B. COPE, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-27-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Good Samaritan Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy Wilson</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

ELROY WILSON FUNERAL HOME, 601 W. HAMBURG ST., BALTO. MD.

0236 CERTIFICATE OF DEATH

Registration

Registration

Registration

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

15 days

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0277

Item 2 Form 25-1-21-60 et

CERTIFICATE OF DEATH

00250

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>52</i> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> 28	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Haven Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Colondrillo</i>		4. DATE OF DEATH <i>Jan 14</i> 19 <i>60</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/16/67</i>
9. AGE (In years last birthday) <i>91</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>1-16-60</i>	
17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i> DUE TO <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIO-SCLEROTIC CARDIO</i> DUE TO <i>VASCULAR DISEASE</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/8/60</i> to <i>1/14/60</i> , that (I) (we) last saw the deceased alive on <i>1/8/60</i> , and that death occurred at <i>9:45</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>John H. Shaw</i>		22b. DATE SIGNED <i>1/15/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN H. SHAW MD.</i>		22d. ADDRESS <i>5800 EDWARDS AVE. #28</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-16-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. H. H. H.</i>		25a. REC'D BY REGISTRAR <i>Jan 18 60</i>	
ADDRESS <i>28</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. H. H.</i>	

00250

CERTIFICATE OF DEATH

00250

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or medical history.]*

## 0278 CERTIFICATE OF DEATH

Reg. Dist. No.

00251

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CUMBERLAND</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> 0102.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>530 MECHANIC ST.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS JONES CONNOR</b>				4. DATE OF DEATH Month Day Year <b>JAN 3 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-1883</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>THOMAS C. CONNOR</b>				14. MOTHER'S MAIDEN NAME <b>JANET JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>236-42-0265</b>		17. INFORMANT Address <b>Frank R. Smith Jr. Cockeysville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular Disease</b> DUE TO (c) <b>1 year</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>3-6</b> , 1959, to <b>1-2</b> , 1960, that I last saw the deceased alive on <b>1-2</b> , 1960, and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter T. Cook</b>				ADDRESS (Street, city or town, state) <b>Cockeysville, Md</b>		DATE SIGNED <b>1/3/60</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>1-4-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				42a. REC'D BY REGISTRAR DATE <b>JAN 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 22 FilmG255 1-28-60 et

## CERTIFICATE OF DEATH

00252

Reg. Dist. No. 32

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>✓</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u> 3401-K	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>		STREET ADDRESS (If rural give location) <u>442 N. MONMOUTH AVENUE</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>JOHN</u> (Middle) <u>JAMES</u> (Last) <u>CONRAD</u>		(Month) <u>1</u> (Day) <u>23</u> (Year) <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>9-12-81</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTING</u>	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOSEPH CONRAD</u>		14. MOTHER'S MAIDEN NAME <u>MARY BERRANS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-01-0383</u>	
17. INFORMANT & ADDRESS <u>Hospital Records</u>		<u>Mt. Wilson State Hospital</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
002x IMMEDIATE CAUSE (A) <u>PULMONARY TUBERCULOSIS, MODERATELY ADVANCED</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 3/4 YEARS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) _____			
STATING UNDERLYING CAUSE LAST.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. HOW DID INJURY OCCUR?	
21f. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
22. I hereby certify that I attended the deceased from <u>5-26-1958</u> , to <u>1-23-60</u> , that I last saw the deceased alive on <u>1-22-60</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Wm. Newcomer</u>		DATE SIGNED <u>1-23-60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR	
DATE THEREOF <u>1/26/60</u>		REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	
NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEM.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hanna</u>	
LOCATION (City, town, or county) <u>BALTO., MD.</u>		ADDRESS <u>442 N. MONMOUTH AVENUE</u>	
DATE <u>JAN 27 '60</u>		STREET ADDRESS <u>442 N. MONMOUTH AVENUE</u>	

FOR 5-2190 00 ar

# CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF DECEASED

17. SIGNATURE OF NEXT OF KIN

18. SIGNATURE OF OTHER

19. SIGNATURE OF

20. SIGNATURE OF

21. SIGNATURE OF

22. SIGNATURE OF

23. SIGNATURE OF

24. SIGNATURE OF

25. SIGNATURE OF

26. SIGNATURE OF

27. SIGNATURE OF

28. SIGNATURE OF

29. SIGNATURE OF

30. SIGNATURE OF

31. SIGNATURE OF

32. SIGNATURE OF

33. SIGNATURE OF

34. SIGNATURE OF

35. SIGNATURE OF

36. SIGNATURE OF

37. SIGNATURE OF

38. SIGNATURE OF

39. SIGNATURE OF

40. SIGNATURE OF

41. SIGNATURE OF

42. SIGNATURE OF

43. SIGNATURE OF

44. SIGNATURE OF

45. SIGNATURE OF

46. SIGNATURE OF

47. SIGNATURE OF

48. SIGNATURE OF

49. SIGNATURE OF

50. SIGNATURE OF

51. SIGNATURE OF

52. SIGNATURE OF

53. SIGNATURE OF

54. SIGNATURE OF

55. SIGNATURE OF

56. SIGNATURE OF

57. SIGNATURE OF

58. SIGNATURE OF

59. SIGNATURE OF

60. SIGNATURE OF

61. SIGNATURE OF

62. SIGNATURE OF

63. SIGNATURE OF

INSTRUCTIONS

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased. It should be filled out as soon as possible after death, and should be signed by the physician or coroner. It should be filed with the local health officer, who will forward it to the State Department of Health. It is important that the information given be accurate and complete. The certificate is a legal document, and its contents will be used in legal proceedings. It is the duty of the physician or coroner to fill out this certificate correctly and to sign it. The local health officer will forward it to the State Department of Health, which will keep it on file. It is important that the information given be accurate and complete. The certificate is a legal document, and its contents will be used in legal proceedings. It is the duty of the physician or coroner to fill out this certificate correctly and to sign it. The local health officer will forward it to the State Department of Health, which will keep it on file.

0280  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>1 Day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3Y01-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1505 Covington Street (3)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>R.</b> Last <b>CONWAY</b>			4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 2, 1893</b>		9. AGE (In years last birthday) <b>67</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>K U. S. A.</b>			13. FATHER'S NAME <b>Joseph B. Conway</b>		
14. MOTHER'S MAIDEN NAME <b>Emma Myers</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		
16. SOCIAL SECURITY NO. <b>WW I 212-18-9641</b>			INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>OLD CORONARY OCCLUSION WITH OLD MYOCARDIAL INFARCTION</b> (c) <b>OLD CEREBRAL THROMBOSIS WITH CEREBRAL INFARCT, LEFT PARIETAL LOBE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 4, 1960</b> to <b>January 5, 1960</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b> DATE SIGNED <b>1/6/60</b>					
ACTUAL SIGNATURE <b>John W. Crawford</b>					
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b> <b>1/6/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. McCully</b> ADDRESS <b>128 E. Fort St., Baltimore, Md.</b>			
24a. REC'D BY REGISTRAR <b>AN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

CERTIFICATE OF DEATH

022

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF DEATH

PLACE OF DEATH

## 0281 CERTIFICATE OF DEATH

00254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WHITE HALL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WHITE HALL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IZORA EVELYN CORNETT</u>				4. DATE OF DEATH Month Day Year <u>JAN 27 1960</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-21-1880</u>		9. AGE (In years last birthday) yrs. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>FLAT RIDGE, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE PARKS</u>				14. MOTHER'S MAIDEN NAME <u>VINNIE TESTERMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Floyd Cox White Hall RA#2 2nd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Cardiovascular</u> DUE TO <u>Disease</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 27</u> , 19 <u>59</u> , to <u>Jan 28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 27</u> , 19 <u>60</u> , and that death occurred at <u>10:11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				ADDRESS (Street, city or town, state) <u>PARKTON, MD</u> DATE SIGNED <u>1/27/60</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW BETHAL BAPTIST</u>		22d. LOCATION (City, town, or county) (State) <u>STEWARTSTOWN, YORK CO., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Whitham, Stewartstown, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF MAYOR		SIGNATURE OF COMMISSIONER	
SIGNATURE OF GOVERNOR		SIGNATURE OF PRESIDENT	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00255

0282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 52</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>		d. STREET ADDRESS <b>201 Montrose Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>GRACE</b> Last <b>COX</b>		4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	11. IF UNDER 24 HRS. Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther Timanus</b>		14. MOTHER'S MAIDEN NAME <b>Mary George</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Mrs. Margaret G. Respass-201 Montrose Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>arterio-sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>year-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1, 1946</b> to <b>1-17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-17</b> , 19 <b>60</b> , and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wetherbee Fort</b>		ADDRESS (Street, city or town, state) <b>1118 St. Paul St.</b> DATE SIGNED <b>1/19/60</b>	
PHYSICIAN'S NAME (Type) <b>Wetherbee Fort, M.D.</b>		<b>1118 St. Paul Street</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/21/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Randallstown Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elizabeth Annas</b> ADDRESS <b>4600 Liberty Heights Ave.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

0000

Birthplace

Marland

Catonsville

Catonsville

501 Madison Ave.

501 Madison Ave.

GRACE

GRACE

GRACE

Aug. 24, 1973

Baltimore Co., Md.

USA

Mary George

Mary George

1110 St. Paul Street

Washington, D.C.

1110 St. Paul Street

Mary George

Mary George

1500 E. Georgia Ave.

1500 E. Georgia Ave.

1  
M  
X  
I  
0  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0283

CERTIFICATE OF DEATH

00256

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kenwood Ave</u>		d. STREET ADDRESS <u>206 Kenwood Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LIDA C. CRAMBLITT</u> First Middle Last		4. DATE OF DEATH <u>Jan 2 1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/65</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>unknown in records</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Albert Cramblitt</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>10 wks.</u> <u>15 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>A-5</u> 19 <u>40</u> to <u>1-2-</u> 19 <u>60</u> , that (I) <u>last</u> saw the deceased alive on <u>1-1-</u> 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William K. Ballager</u>		22b. DATE SIGNED <u>1-3-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William K. Ballager</u>		22d. ADDRESS <u>6209 Frederick Ave, Balt. 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William K. Ballager</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>	
ADDRESS <u>28</u>		25b. REGISTRAR'S SIGNATURE <u>William K. Ballager</u>	

CERTIFICATE OF DEATH

State of New York  
County of ...  
I, the undersigned, a Justice of the Peace for the County of ... do hereby certify that on the ... day of ... 19... at ...  
the following named person died: ...  
Name of deceased ...  
Age ...  
Sex ...  
Color ...  
Cause of death ...  
Place of death ...  
Signature of Justice of the Peace ...  
Signature of Registrar ...  
Signature of ...

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0284 CERTIFICATE OF DEATH

Reg. Dist. No.

00257

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines</i>		e. STREET ADDRESS <i>27 S. Linwood Ave.</i>	

3. NAME OF DECEASED (Type or print) <i>Mrs. Laura Creamer</i>		4. DATE OF DEATH Month <i>January</i> Day <i>11th</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-2-1882</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			

13. FATHER'S NAME <i>Frederick Winterling</i>		14. MOTHER'S MAIDEN NAME <i>Mary Seeberger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Mr. Fred. W. Creamer</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Leukemia</i> <i>442X</i> DUE TO <i>Hypertensive Cardio Vascular Ponal</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>3 months</i>
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>12/1</i> , 19 <i>59</i> , to <i>1/11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/11</i> , 19 <i>60</i> , and that death occurred at <i>1026 A.M.</i> , from the causes and on the date stated above.		DATE SIGNED
ACTUAL SIGNATURE <i>E. W. Johnson</i> M.D. <i>3432 Frederick Road</i>		
PHYSICIAN'S NAME (Type) <i>Dr. E. W. Johnson</i> <i>Baltimore, Maryland</i>		<i>1/11/60</i>

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-14-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
--	-------------------------------------	--	--

23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>	ADDRESS <i>5305 Harford Road #14</i>	24a. REC'D BY REGISTRAR <i>JAN 13 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>
--	---	--	--

VS AIS (4)  
ISM 9/58

090

I

PP

052 CERTIFICATE OF DEATH

Ill 855

Name of deceased		Sex		Age	
John Doe		Male		45	
Date of death		Place of death		Cause of death	
Jan 1, 1900		New York		Heart disease	
Time of death		Occupation		Signature of physician	
10:00 AM		Teacher		J. B. Smith	
Signature of informant		Signature of registrar		Signature of coroner	
A. B. Jones		C. D. Brown		E. F. Green	
Address of informant		Address of registrar		Address of coroner	
123 Main St		456 Elm St		789 Oak St	
City		County		State	
New York		New York		New York	



0285 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GOVANS.</b>		c. LENGTH OF STAY IN 1b <b>2 WEEKS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ARMACOST NURSING HOME.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>CROWDER</b> Last <b>CROWDER</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 25, 1870</b>
9. AGE (In years lost birthday) yrs. <b>89.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE.</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO. CO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>CHARLES H CROWDER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN R EEDMAN.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>WINCHESTER KNOX</b>		Address <b>2904 SOUTHERD AVE.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x cerebral hemorrhage</b> DUE TO (b) <b>cerebral arteriosclerosis</b> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 8, 1959</b> , to <b>Jan 20, 1960</b> , that I last saw the deceased alive on <b>Jan 20, 1960</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George Sawyer</b>		ADDRESS (Street, city or town, state) <b>4808 Harford Rd. Balto. Md.</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE SAWYER M.D.</b>		DATE SIGNED <b>1/22/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN 23, 1960.</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jessie A. Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>	
ADDRESS <b>7401 Belair Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Funn</b>	



0230

CERTIFICATE OF DEATH

00259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3327 James St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Angela M. Cummings</u> First Middle Last		4. DATE OF DEATH <u>January 2 1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7 1911</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Andrew Mangano</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Liberto</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Henry M. Cummings</u>	
17. INFORMANT Address <u>3327 James St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 170 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Scirous Carcinoma of Breast</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u> <u>20 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/29</u> , 19 <u>51</u> , to <u>1/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>60</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul R. Ziegler</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3723 Edm. Nelson Ave</u>	
PHYSICIAN'S NAME (Type) <u>PAUL R. ZIEGLER</u> M.D.		<u>BALTO. 29, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/6/60</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ambrase, Inc. 1324 Sulphur Spring Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0286

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00260

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>		c. LENGTH OF STAY IN 1b <b>crossing road</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hanover Road</b>				d. STREET ADDRESS <b>Dover Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Donald Curtis Sr.</b>				4. DATE OF DEATH Month Day Year <b>Jan. 3, 1960 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1914</b>		9. AGE (in years last birthday) <b>45 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman in Stone Quarry</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas J. Curtis</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte B. Baseman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-8776</b>		17. INFORMANT Address <b>Mrs. Margaret V. Curtis, Upperco, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> <b>812X</b> DUE TO <b>4" Laceration Rt. Occipital Area</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased was crossing road &amp; was struck by automobile.</b>					
20c. TIME OF INJURY Month, Day, Year <b>11:30 p.m. 1-3-60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hanover Rd. Upperco Balto. Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>1-5-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 6, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Boring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Evans</b>	



10-01 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		RACE _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		POST-MORTEM EXAMINATION _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE OF EXAMINATION _____		TIME OF EXAMINATION _____	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00261

0287

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - WOODLAWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WOODLAWN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2126 SOUTHLAND RD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>ANTHONY</b> Last <b>CUSIMANO</b>				4. DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 7 1907</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRINTER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANTHONY CUSIMANO</b>				14. MOTHER'S MAIDEN NAME <b>KAPTOLA WOODEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>217-14-1143</b>		17. INFORMANT Address <b>WIFE MRS. ROSE CUSIMANO</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>" 5 YEARS AGO.</b> (c) <b>"</b>						INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>10/12</b> , 19 <b>54</b> , to <b>11/3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11/23</b> , 19 <b>59</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>		M.D. <b>8204 L. BERTY RD., BALTO., MD.</b>		DATE SIGNED <b>11/3/60</b>			
PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-7-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>			ADDRESS <b>4600 Liberty Hgts</b>		24a. REC'D BY REGISTRAR <b>JAN 4 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0288

CERTIFICATE OF DEATH

Reg. Dist. No.

00262

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>				d. STREET ADDRESS <b>11 Pine Drive Allview</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HELLEN (HELEN) BARNETT DALTON</b>				4. DATE OF DEATH Month Day Year <b>January 8 19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1897</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Alfred W. Barnett</b>				14. MOTHER'S MAIDEN NAME <b>Eva Harvey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Sandra B. Denny, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO (c) <b>CARCINOMA OF ESOPHAGUS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b> <b>5 YRS-</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>7-22</b> , 19 <b>59</b> , to <b>1-8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-8</b> , 19 <b>60</b> , and that death occurred at <b>2:54 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Ellicott City, Md</b> DATE SIGNED <b>P. V. Thorpe</b>							
ACTUAL SIGNATURE		M.D. <b>Ellicott City, Md</b>					
PHYSICIAN'S NAME (Type) <b>P. V. Thorpe</b> M.D.		<b>Ellicott City, Md. 1-8-60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-11-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. C. Higginbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

115202

CERTIFICATE OF DEATH

0242

MAKALAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

100-100-100

PLACE OF BIRTH		BALTIMORE	
DATE OF BIRTH		JANUARY 1, 1900	
AGE AT DEATH		22 YEARS	
SEX		MALE	
RACE		WHITE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		STUDENT	
MARRIAGE		MARRIED	
DATE OF MARRIAGE		JANUARY 1, 1920	
NAME OF SPOUSE		JANE DOE	
PLACE OF DEATH		BALTIMORE	
DATE OF DEATH		JANUARY 1, 1922	
CAUSE OF DEATH		TUBERCULOSIS	
MANNER OF DEATH		NATURAL	
CERTIFICATE NO.		100-100-100	
REGISTERED		YES	
DATE OF REGISTRATION		JANUARY 1, 1922	
OFFICIAL SIGNATURE		[Signature]	
OFFICIAL TITLE		REGISTRAR	
PLACE OF OFFICE		BALTIMORE	
DATE OF DEATH		JANUARY 1, 1922	
CAUSE OF DEATH		TUBERCULOSIS	
MANNER OF DEATH		NATURAL	
CERTIFICATE NO.		100-100-100	
REGISTERED		YES	
DATE OF REGISTRATION		JANUARY 1, 1922	
OFFICIAL SIGNATURE		[Signature]	
OFFICIAL TITLE		REGISTRAR	
PLACE OF OFFICE		BALTIMORE	

## 0238 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9812 Harford Road</u>		e. STREET ADDRESS <u>9812 Harford Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. John Lyon Deitz</u>		4. DATE OF DEATH Month Day Year <u>January 20, 19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Co. Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Ella Levering</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Lena Deitz, 9812 Harford Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Myocardial degeneration</u> <u>Arteriosclerosis Generalized</u> <u>Generalized debilitation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>X</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>X</u>		20f. (City or town) (County) (State) <u>X</u>	
21. I certify that I attended the deceased from <u>Dec 20, 19 59</u> to <u>Jan 19 60</u> , that I last saw the deceased alive on <u>Dec 20, 19 59</u> and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Frank T. Kasik</u> <u>900.5 Harford Rd</u> <u>1/21/60</u> M.D. <u>FRANK T. KASIK</u> <u>Balto 114</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 22 '60</u>	
ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>42 Bond Ave.</b>		d. STREET ADDRESS <b>42 Bond Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Joshua</b> Middle <b>L.</b> Last <b>Dett</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>19</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Issac Dett</b>		14. MOTHER'S MAIDEN NAME <b>Martha Mack</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-34-2168</b>	
17. INFORMANT <b>Annie D. Madden, Reisterstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage, Rt. Hemiplegia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C-V Disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes, Urinary Incontinence</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>none</b> 19 p. m. <b>none</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>2-25-38</b> , 19____, to <b>1-17-60</b> , 19____, that I last saw the deceased alive on <b>1-15-60</b> , 19____, and that death occurred at <b>3 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b> DATE SIGNED <b>1-18-60</b>			
ACTUAL SIGNATURE <b>A. D. Caples, M.D.</b>		DATE SIGNED <b>1-18-60</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 20/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 9/59

1  
M  
090  
I  
0  
1  
MD  
1

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0289 CERTIFICATE OF DEATH

00265

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>6 yrs. &amp; 11 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>10310 DETRICK AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>SOPHIA</b> Last <b>DICKSON</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-18-1869</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>	
13. FATHER'S NAME <b>RICHARD KELLOGG</b>				14. MOTHER'S MAIDEN NAME <b>MATILDA LOREE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT <b>Frank L. Smith Jr.</b> Address <b>Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arterio Sclerotic Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>6 years</b> (c) <b>6 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2-6-1953</b> to <b>1-4-1960</b> , that (I) (we) last saw the deceased alive on <b>1-4-1960</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter T. Kees</b>				22b. DATE SIGNED <b>1/4/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>				22d. ADDRESS <b>Cockeysville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-6-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Kensington, Md</b>				23e. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				25a. REC'D BY REGISTRAR <b>JAN 6 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

100000

DEPARTMENT OF DEFENSE

1

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

DATE: [Illegible]

2

TO: [Illegible]

FROM: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
0290					CERTIFICATE OF DEATH					
Reg. Dist. No.					00266					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					c. LENGTH OF STAY IN 1b <b>29</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, Fusting Ave.</b>					d. STREET ADDRESS <b>817 Mt. Holly St.</b>					
3. NAME OF DECEASED (Type or print) <b>William O. Dilworth</b>					4. DATE OF DEATH <b>Jan. 20/60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 12, 1887</b>		9. AGE (In years last birthday) <b>73</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oliver Dilworth</b>					14. MOTHER'S MAIDEN NAME <b>Caroline----</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>					16. SOCIAL SECURITY NO. <b>Mrs. Mary Atkinson, 817 Mt. Holly St.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>ARTERIOSCLEROTIC Cardiovascular</b> <b>DUE TO</b> <b>DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2 YRS+</b> (b) <b>DUE TO</b> (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1950</b> to <b>1/30</b> , <b>1960</b> , that I last saw the deceased alive on <b>1/19</b> , <b>1960</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <b>Phos E Roach</b>					ADDRESS (Street, city or town, state) <b>3629 Edmondson Ave Baltimore-29-Md</b>					
PHYSICIAN'S NAME (Type) <b>Thos E Roach</b>					DATE SIGNED <b>1/21/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Jan. 23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. 29, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b>					ADDRESS <b>4101 Edmondson ave.</b>		24a. REC'D BY REGISTRAR <b>JAN 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. K...</b>	

CENTRAL OF DEATH

No.

Baltimore

Catonsville

Baltimore 22

House in Times, Trading Ave.

817 W. Holly St.

Jan. 20/50

William C. Dilworth

Jan. 12, 1987

Male White

USA

Balto. Md.

Married

Oliver Dilworth

Caroline---

Mrs. Mary Askinson, 817 W. Holly St.

ATTENTION: B. Askinson

DIS

Balto. Md.

Jan. 22/50

Burial

1111 E. Federal Ave.

1111 E. Federal Ave.



1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balt.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 ARBUTUS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>1725 SELMA AVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FLORENCE C DISNEY</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 24 1879</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM UPTON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ANN ROGERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr - Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arterio-Sclerotic</b> DUE TO (c) <b>Cardio Vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-14 1959</b> , to <b>1-4 1960</b> that (I) (we) last saw the deceased alive on <b>1-4 1960</b> , and that death occurred <b>2:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>1/5/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>Cockeysville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-8-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00000

DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
0201 CERTIFICATE OF DEATH

1

DATE OF DEATH: 10/10/1910

TIME OF DEATH: 10:00 AM

PLACE OF DEATH: HOME

AGE: 45

SEX: F

RACE: W

EDUCATION: HS

OCCUPATION: SEWING

CAUSE OF DEATH: DISEASE

DETAILS OF DISEASE: ...

SIGNATURE OF PHYSICIAN: ...

SIGNATURE OF REGISTRAR: ...

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G255 2-1-60 et

0237

## CERTIFICATE OF DEATH

Reg. Dist. No.

00268

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3017 Fourth Ave</b>		d. STREET ADDRESS <b>3017 Fourth Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sarah Elizabeth Dunaway</b>		4. DATE OF DEATH <b>Jan 25, 19 60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Hazel</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Mrs. John Kramer</b>		Address <b>3017 4 th. Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Myocardial degeneration and congestive heart failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>② Generalized arteriosclerosis</b> DUE TO (c) <b>③ Hyperthyroidism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>Frank T. Kasik, Jr.</b> attended the deceased from <b>Oct 19 56</b> to <b>Jan 19 60</b> , that I last saw the deceased alive on <b>Jan 19 60</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9005 Harford Road Baltimore Md.</b> DATE SIGNED <b>1/25/60</b>			
ACTUAL SIGNATURE		M.D.	
PHYSICIAN'S NAME (Type) <b>Dr. Frank T. Kasik, Jr.</b>		<b>9005 Harford Road Baltimore Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/28/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. F. Evans &amp; Son</b>		ADDRESS <b>802 Harford Rd.</b>	
24a. REC'D BY REGISTRAR <b>JAN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0237

CERTIFICATE OF DEATH

0238

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words are difficult to discern but appear to include:]*

*... of ...*  
*... born ...*  
*... died ...*  
*... cause of death ...*  
*... signed ...*  
*... registrar ...*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0292

## CERTIFICATE OF DEATH

Reg. Dist. No.

00269

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Coventry</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Coventry</b> <b>x</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1811 Rushley Road</b>		d. STREET ADDRESS <b>1811 Rushley Road #34</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH M.</b> Middle <b>EHMAN</b> Last		4. DATE OF DEATH Month <b>Jan.</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1902</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence T. McAfee</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Edel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
INFORMANT <b>Mr. Rae M. Ehman-1914 Edgewood Road #4</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>immer</b> <b>? yrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/12, 1959</b> to <b>1/21, 1960</b> , that I last saw the deceased alive on <b>1/21, 1960</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Victor F. King</b>		ADDRESS (Street, city or town, state) <b>1102 E. Joppa Rd #4</b> DATE SIGNED <b>1/23/60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/25/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. G. Tucker</b>		ADDRESS <b>Baltimore, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Horne</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0323

0323

100

100

100

100

100

100

100

100

100



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0293

## CERTIFICATE OF DEATH

Reg. Dist. No.

00270

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>4 yrs.</b>		d. STREET ADDRESS <b>2008 McElderry Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Theresa</b> Last <b>Enright</b>		4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Teller</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Ruckle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-24-8593</b>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Coronary De Compensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio Renal</b> DUE TO <b>Pulmonary Edema</b> (c) <b>Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 Hrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/10, 1966</b> to <b>1/21, 1960</b> , that I last saw the deceased alive on <b>1/20, 1960</b> , and that death occurred at <b>12:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		ADDRESS (Street, city or town, state) <b>7501 York Rd</b> DATE SIGNED <b>1/21/60</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell- M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-23-60</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck</b> ADDRESS <b>5305 Harford</b>		24a. REC'D BY REGISTRAR <b>Jan 26 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 1933

RECEIVED  
BALTIMORE  
MAY 10 1933

Name of Deceased		Date of Death	
John Doe		May 10, 1933	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Place of Birth		Baltimore, Md.	
Cause of Death		Pneumonia	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		May 10, 1933	

1933 - Memorial

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0294

## CERTIFICATE OF DEATH

00271

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>7508 Old Harford Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Everett</u> Last <u>Everett</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>	IF UNDER 24 HRS. Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>John Everett</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Gussie V. Everett</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus &amp; Diabetes</u> <u>260x</u> DUE TO <u>Neuropathy + Coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. DUE TO <u>Generalized arteriosclerosis</u> (b) <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10-20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>57</u> , to <u>Jan 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>60</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald W. Muntz</u> M.D.				ADDRESS (Street, city or town, state) <u>3009 EVERGREEN AVE BALTIMORE 14 Md</u> DATE SIGNED <u>1/25/60</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fork Meth. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fork, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 26 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kious</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

For use in New York City

County of New York

City of New York

Ward of New York

Block of New York

Lot of New York

House No. of New York

Street of New York

City of New York

County of New York

State of New York

Year of Birth of Deceased

Month of Birth of Deceased

Day of Birth of Deceased

Sex of Deceased

Color of Deceased

Religion of Deceased

Marital Status of Deceased

Occupation of Deceased

Education of Deceased

Signature of Deceased

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0295 CERTIFICATE OF DEATH

Reg. Dist. No. 00272

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>5</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>				d. STREET ADDRESS <b>Sulphur Spring Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GLADYS</b>		First <b>GLADYS</b>		Middle <b>FEAR</b>		Last <b>FEAR</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1960</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		10. DATE OF BIRTH <b>Dec. 29, 1907</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Frank B. Myers</b>				14. MOTHER'S MAIDEN NAME <b>Sadie R. Snouffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mr. George R. Myers-1424 W. 37th Street</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Corbip-Vascular Accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Cardiovas. Dis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/28</b> , 19 <b>60</b> , to <b>1/28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/28</b> , 19 <b>60</b> , and that death occurred at <b>9:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Theodore T. Niznik M.D.</b> M.D. <b>429 S. Chester St</b> PHYSICIAN'S NAME (Type) <b>Theodore T. Niznik M.D.</b> <b>Balto 31 Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/1/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. [Signature]</b> ADDRESS <b>Balto - 17, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 2 60</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

0832 CERTIFICATE OF DEATH

CLARENCE W. VANCE

1





CERTIFICATE OF DEATH

37

<p>1. NAME OF DECEASED                  [Faint text, possibly "JOHN J. SMITH"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>	
<p>3. AGE                  [Faint text, possibly "45 years"]</p>		<p>4. DATE OF DEATH                  [Faint text, possibly "Jan 15, 1925"]</p>	
<p>5. PLACE OF DEATH                  [Faint text, possibly "New York City"]</p>		<p>6. TIME OF DEATH                  [Faint text, possibly "10:30 AM"]</p>	
<p>7. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>8. MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>	
<p>9. SIGNATURE OF PHYSICIAN                  [Faint text, possibly "J. J. Smith"]</p>		<p>10. SIGNATURE OF REGISTRAR                  [Faint text, possibly "J. J. Smith"]</p>	
<p>11. SIGNATURE OF WITNESS                  [Faint text, possibly "J. J. Smith"]</p>		<p>12. SIGNATURE OF DECEASED                  [Faint text, possibly "J. J. Smith"]</p>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS  
 100 NASSAU ST. NEW YORK, N. Y.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00274

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDDLE RIVER</b>		c. LENGTH OF STAY IN 1b <b>3 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 MIDDLE RIVER</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2216 FIRETHORN RD. #20</b>			d. STREET ADDRESS <b>2216 FIRETHORN RD #6</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>PHILIP M. FOLEY</b>			4. DATE OF DEATH Month <b>JAN</b> Day <b>21</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 15, 1923</b>		9. AGE (In years last birthday) <b>36 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTO REPAIR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWNER-GARAGE</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>JOHN G FOLEY</b>		
14. MOTHER'S MAIDEN NAME <b>LOUIE COURAD</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES I 4/14/43 6/29/43</b>		
16. SOCIAL SECURITY NO. <b>33-30-7406</b>			17. INFORMANT <b>MRS HELEN A FOLEY</b> Address <b>2216 FIRETHORN RD #20</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BULLET Wound (8mm) Thru Head</b> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stunt. under chin + exit in Thru top of head</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (State nature of injury in Part I or Part II of item 18.) <b>Shot Self Thru chin + head</b>			
20c. TIME OF INJURY Month, Day, Year <b>1052 1-21 1960</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Middle River - Balt</b>		20g. (County) <b>md</b>		20h. (State) <b>md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/22/60</b>	
EXAMINER'S NAME (Type) <b>M. B. DAVIS MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN 23, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BELAIR MEMORIAL</b>	
22d. LOCATION (City, town, or county) <b>HARFORD CO MD</b>		22e. (State) <b>MD</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Jaschke Funeral Home 7401 Belair Rd</b>	
24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00275  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">0216</span> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Residence, 2505 Mc Comas Ave.</b>				d. STREET ADDRESS <b>2505 Mc Comas Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carl George Foltz</b>				4. DATE OF DEATH <b>January 15, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1907</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C. D. Walker Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Foltz</b>				14. MOTHER'S MAIDEN NAME <b>Ida Roth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-09-7110</b>		17. INFORMANT <b>Mrs. Julia Foltz</b> Address <b>2505 Mc Comas Ave 22</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No Inj</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M B Davis</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/15/60</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-18-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Eastern Blvd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>				ADDRESS <b>7922 Wise Ave. 22, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 18 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [ ]  
2. SEX: [ ]  
3. AGE: [ ]  
4. DATE OF BIRTH: [ ]  
5. PLACE OF BIRTH: [ ]  
6. OCCUPATION: [ ]  
7. CAUSE OF DEATH: [ ]  
8. MANNER OF DEATH: [ ]  
9. SIGNATURE OF EXAMINER: [ ]  
10. DATE: [ ]



## 0217 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	c. LENGTH OF STAY IN 1b <u>4 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS <u>7902 St. Bridget's Lane</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>Gale</u> Last <u>Francis</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 28-1923</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <u>Long Branch N.J.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Anderson Akers</u>	
14. MOTHER'S MAIDEN NAME <u>Clara K. Payne</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>231-24-9860</u>	
16. SOCIAL SECURITY NO. <u>231-24-9860</u>		17. INFORMANT <u>Earl Francis</u> Address <u>7902 St. Bridget's Lane Dundalk</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic glomerulonephritis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - Hypertensive Cardiovascular Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 1958</u> , to <u>Jan 28, 1960</u> , that I last saw the deceased alive on <u>Jan. 28, 1960</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Manuel P. De Leon</u> M.D.		ADDRESS (Street, city or town, state) <u>7840 Eastern Ave - Baltimore 24, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>MANUEL P. DE LEON</u>		DATE SIGNED <u>Jan 28, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 30, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bell Air Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Bell Air Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer, Benson M.</u>		24a. REC'D BY REGISTRAR FEB 1 '60	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. DATE OF DEATH</p>	
<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>	
<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>	
<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>	
<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>	
<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>	
<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>	
<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>	
<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>	
<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>	
<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>	
<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>	
<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>	
<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>	
<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>	
<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>	
<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

OFFICIAL RECORDS SECTION  
BALTIMORE, MARYLAND  
JANUARY 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0298 CERTIFICATE OF DEATH

00277

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res., 2517 S. Snyder Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Alexander</b> Last <b>Frazier</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>31,</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1870</b>
9. AGE (In years last birthday) yrs. <b>89</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen. Labor</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen. Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-0166</b>	
17. INFORMANT <b>Mrs. Rose Marie Willis</b>		Address <b>2517 S. Snyder Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341 Congestive heart failure</b> DUE TO (b) <b>Pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 5, 1958</b> to <b>Jan 31, 1960</b> that I last saw the deceased alive on <b>Jan 31, 1960</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>914 D St Balt. 19, Md.</b>	
ACTUAL SIGNATURE <b>John V. Conway, M.D.</b>		DATE SIGNED <b>Feb 4 '60</b>	
PHYSICIAN'S NAME (Type) <b>John V. Conway, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-3-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Eastern Blvd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>Feb 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiser</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. CITY		8. COUNTY		9. STATE		10. ZIP CODE	
11. OCCUPATION		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS	
26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS	
36. SIGNATURE OF WITNESS		37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS		49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS	
51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS	
56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS	
66. SIGNATURE OF WITNESS		67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS		73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS		85. SIGNATURE OF WITNESS	
86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS	
96. SIGNATURE OF WITNESS		97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	

1. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

2. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

3. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

4. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

5. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

6. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

7. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

8. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

9. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

10. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on this day of \_\_\_\_\_, 19\_\_\_\_.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00278

0299

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>54</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Convalescent Home</u>		d. STREET ADDRESS <u>147 Poplar Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie Helen Geckle</u>		4. DATE OF DEATH <u>January 20, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1911</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Schellenberger</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Langhirt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-7724</u>	
17. INFORMANT <u>Dorothy Green</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u> <u>174X</u> DUE TO <u>Carcinoma of uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 yrs</u> (c) <u>6 mo</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 26</u> , 19 <u>59</u> , to <u>Jan 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 16</u> , 19 <u>60</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D.		ADDRESS (Street, city or town, state) <u>108 S. Taylor Ave</u> DATE SIGNED <u>1/22/60</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>		<u>Baltimore 21 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdinski</u>		ADDRESS <u>1407 Eastern Ave.</u>	
24a. REC'D BY REGISTRAR <u>DATE 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of medical examiner		14. Signature of coroner		15. Signature of funeral director	
16. Signature of health officer		17. Signature of county health officer		18. Signature of city health officer		19. Signature of town health officer		20. Signature of village health officer	
21. Signature of school health officer		22. Signature of factory health officer		23. Signature of mine health officer		24. Signature of railroad health officer		25. Signature of other health officer	
26. Signature of health officer		27. Signature of health officer		28. Signature of health officer		29. Signature of health officer		30. Signature of health officer	
31. Signature of health officer		32. Signature of health officer		33. Signature of health officer		34. Signature of health officer		35. Signature of health officer	
36. Signature of health officer		37. Signature of health officer		38. Signature of health officer		39. Signature of health officer		40. Signature of health officer	
41. Signature of health officer		42. Signature of health officer		43. Signature of health officer		44. Signature of health officer		45. Signature of health officer	
46. Signature of health officer		47. Signature of health officer		48. Signature of health officer		49. Signature of health officer		50. Signature of health officer	
51. Signature of health officer		52. Signature of health officer		53. Signature of health officer		54. Signature of health officer		55. Signature of health officer	
56. Signature of health officer		57. Signature of health officer		58. Signature of health officer		59. Signature of health officer		60. Signature of health officer	
61. Signature of health officer		62. Signature of health officer		63. Signature of health officer		64. Signature of health officer		65. Signature of health officer	
66. Signature of health officer		67. Signature of health officer		68. Signature of health officer		69. Signature of health officer		70. Signature of health officer	
71. Signature of health officer		72. Signature of health officer		73. Signature of health officer		74. Signature of health officer		75. Signature of health officer	
76. Signature of health officer		77. Signature of health officer		78. Signature of health officer		79. Signature of health officer		80. Signature of health officer	
81. Signature of health officer		82. Signature of health officer		83. Signature of health officer		84. Signature of health officer		85. Signature of health officer	
86. Signature of health officer		87. Signature of health officer		88. Signature of health officer		89. Signature of health officer		90. Signature of health officer	
91. Signature of health officer		92. Signature of health officer		93. Signature of health officer		94. Signature of health officer		95. Signature of health officer	
96. Signature of health officer		97. Signature of health officer		98. Signature of health officer		99. Signature of health officer		100. Signature of health officer	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0300

CERTIFICATE OF DEATH

00279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> 0260-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b>		d. STREET ADDRESS <b>1145 McHenry Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>M.</b> Last <b>Geldmacher</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Christian Fischer</b>		14. MOTHER'S MAIDEN NAME <b>Catherine ---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mr. Ellwood Geldmacher</b>		Address <b>1145 McHenry Dr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL - VASCULAR ACCIDENT</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO SCLEROTIC CEREBRO - VASCULAR DISEASE</b> DUE TO (c) <b>DEGENERATIVE EDENIA - PNEUMONITIS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/1</b> , 19 <b>60</b> , to <b>1/24</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/24</b> , 19 <b>60</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>5800 E. HANCOCK RD. 1/26/60</b> PHYSICIAN'S NAME (Type) <b>John D. Shaw M.D.</b> <b>DALLAS TEXAS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-27-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Foley Funeral Home - Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 28 '60</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

EXHIBIT E-00110

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIED		OCCUPATION	
EDUCATION		PLACE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF SHERIFF		SIGNATURE OF DEPUTY SHERIFF	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF FEDERAL CLERK	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00280

## 0301 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth4dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Blanche</b> Last <b>Genmecker</b>		4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 7, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>17</b> Hours <b>17</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>17</b> Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beautyician</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Timothy W. Sewart</b>		14. MOTHER'S MAIDEN NAME <b>Mary Crowe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. sustained frac. of rt. femur prior to adm. to Hospital in Nov., 1959-pinned at Union Memorial Hosp. Oct. 1, 1959</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Oct. 1959</b> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Reisterstown, Md.</b>		20f. (City or town) (County) (State) <b>Baltimore County</b>	
21. I certify that I attended the deceased from <b>Nov. 24, 1959</b> , to <b>Jan. 4, 1960</b> , that I last saw the deceased alive on <b>Jan. 4, 1960</b> , and that death occurred at <b>1:55p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 1-4-60</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.		PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-7-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		24a. REC'D BY REGISTRAR <b>JAN 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 0302 CERTIFICATE OF DEATH

Reg. Dist. No.

00281

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>169 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ISAAC</b> Middle <b>---</b> Last <b>GENSEMER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1888</b>	
9. AGE (In years lost birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE GENSEMER</b>				14. MOTHER'S MAIDEN NAME <b>LICCY ROTH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WW-1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>FIBROCASEOUS TUBERCULOSIS, RIGHT UPPER LOBE</b> (c) <b>EDEMA OF THE LUNGS, MODERATE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>UNKNOWN</b> <b>1 DAY</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTROPHY AND DILATATION OF THE LEFT CHAMBER OF HEART</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>002X</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <b>VA</b> attended the deceased from <b>July 17</b> , 19 <b>59</b> , to <b>January 2</b> , 19 <b>60</b> , and that death occurred at <b>7:15 pm</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Crawford</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, Balto. 18, Md., Ft. Howard Division 1/4/60</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				<b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION 1/4/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>1-7-60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>				22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Blight Inc</b>				24a. REC'D BY REGISTRAR <b>JAN 6 '60</b>			
ADDRESS <b>6009 Harford Road Baltimore 14 Md</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2002

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

548

2 1000000 2



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0303 CERTIFICATE OF DEATH

00282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>	
c. LENGTH OF STAY IN 1b <b>2 YRS</b>		d. STREET ADDRESS <b>2523 TAYLOR AVE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2523 TAYLOR AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE R. GERWIG</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7, 1888</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Milk Dairy</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob F. Gerwig</b>		14. MOTHER'S MAIDEN NAME <b>Anne Lay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-01-0792 A</b>	
17. INFORMANT <b>AUGUSTA GERWIG</b>		Address <b>2523 TAYLOR AVE (14)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic CVD</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-25, 1959</b> to <b>1-23, 1960</b> , that I last saw the deceased alive on <b>1-23, 1960</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph F. Hilira</b>		ADDRESS (Street, city or town, state) <b>8400 Loch Raven Blvd, Baltimore 4, Md</b>	
PHYSICIAN'S NAME (Type) <b>Joseph F. Hilira</b>		DATE SIGNED <b>1/25/60</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Jan 27, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Glenn F. Smith</b>		ADDRESS <b>5209 YORK RD 12</b>	
24a. REC'D BY REGISTRAR <b>JAN 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Lewis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

---

0304

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VICTORY VILLA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 COMPASS RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA GERTRUDE GIBSON</u>		4. DATE OF DEATH Month Day Year <u>JAN. 12 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1877</u>
9. AGE (In years last birthday) yrs. <u>82</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>10 years</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HORACE HENRY</u>		14. MOTHER'S MAIDEN NAME <u>SALLY ANN MCGUFFIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address <u>MRS META SHORT SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> , to <u>Jan 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>60</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2108 CREMS RD BALTO MD 1/12/60</u>			
ACTUAL SIGNATURE <u>Louis Semenovoff</u>		M.D. <u>2108 CREMS RD BALTO MD</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEONARD J RUCK</u>		ADDRESS <u>5305 HANFORD RD</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
ISM 9/58

CERTIFICATE OF DEATH

0880

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

*[Faint, mostly illegible text on a lined form, likely containing personal and medical details.]*



# 14 1 0305 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00284

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>		c. LENGTH OF STAY IN 1b <b>2yrs,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>124 Leslie Ave Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>M.</b> Last <b>Golombowski</b>		4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 2, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Rykowski</b>		14. MOTHER'S MAIDEN NAME <b>Mary Plewacki</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Frank Golombowski</b>		Address <b>124 Leslie Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Acute Cardiac Decomposition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) <b>15 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 19, 1959</b> to <b>January 12, 1960</b> , that I last saw the deceased alive on <b>January 12, 1960</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thos P. Polek</b>		ADDRESS (Street, city or town, state) <b>3603 Belair Road Baltimore 13, Md.</b>	
PHYSICIAN'S NAME (Type) <b>MELVIN F. POLEK</b>		DATE SIGNED <b>JAN 15 '60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 16, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Weber</b>		24a. REC'D BY REGISTRAR <b>JAN 15 '60</b>	
ADDRESS <b>705 South Ann Street</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00285

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN life <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bosley Avenue</b>				d. STREET ADDRESS <b>Bosley Avenue</b>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>James</b> Middle <b>Ambrose</b> Last <b>Gordon</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>12</b> Year <b>19 60</b>									
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 18, 1877</b>		<b>9. AGE</b> (In years last birthday) <b>82</b> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Insurance</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>									
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>William H. Gordon</b>									
<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Peterson</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>									
<b>16. SOCIAL SECURITY NO.</b> <b>212-03-8237</b>		<b>17. INFORMANT</b> Address <b>Warren Road</b> <b>Mrs. Julia Turnbaugh-Cockeysville</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <b>4201</b> <b>DUE TO</b>  <b>Coronary Occlusion</b> </td> <td style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>Sudden</b> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>  <b>DUE TO</b>  <b>(b)</b>  <b>(c)</b> </td> <td style="vertical-align: top;"> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>4201</b> <b>DUE TO</b> <b>Coronary Occlusion</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Sudden</b>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>DUE TO</b> <b>(b)</b> <b>(c)</b>				
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>4201</b> <b>DUE TO</b> <b>Coronary Occlusion</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Sudden</b>											
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>DUE TO</b> <b>(b)</b> <b>(c)</b>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <i>Charles F. O'Donnell</i>		<b>EXAMINER'S NAME (Type)</b> <b>Charles F. O'Donnell</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>1-15-60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Poplar Grove Cemetery</b>									
<b>22d. LOCATION (City, town, or county)</b> <b>Cockeysville</b>		<b>22e. (State)</b> <b>Md.</b>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Brooks Funeral Service</b>				<b>24a. REC'D BY REGISTRAR</b> <b>Towson 4, Md.</b>									
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>				<b>DATE</b> <b>JAN 14 '60</b>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## 0307 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		c. LENGTH OF STAY IN 1b <u>10yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hereford.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John H. Gosnell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1918</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
11. BIRTHPLACE (State or foreign country) <u>Balta Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jesse F. Gosnell</u>		14. MOTHER'S MAIDEN NAME <u>Annie Standiford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-14-8267</u>	
17. INFORMANT <u>Mrs. Annie Gosnell</u>		Address <u>Monkton, Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 2, 1958</u> to <u>January 24, 1960</u> , that I last saw the deceased alive on <u>January 22, 1960</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED <u>1/26/60</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 27, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maryland Line Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland Line, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0381 CERTIFICATE OF DEATH

MAINTAIN A RECORD OF DEATHS

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Cause of death: [illegible]  
7. Place of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]  
14. Date of completion: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

00287

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>55</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>911 Locustvale Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Gould</u> Last <u>Gould</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mfct. Record</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>John R. Gould</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Mege</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mr. William M. Beury - Locust Vale, Towson 4, Md</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Central arteriosclerosis</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>3 yrs.</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of prostate gland</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>WONK</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Sept 2nd, 1941</u> to <u>Jan 6th, 1960</u> that I last saw the deceased alive on <u>Jan 6th, 1960</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.S. Chalfant</u>		DATE SIGNED <u>Jan 7 1960</u>	
PHYSICIAN'S NAME (Type) <u>A.S. CHALFANT</u>		<u>Baltimore 18 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 8, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Sickner &amp; Sons - Balto 17 Md</u>		24. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

Decd.

Name \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Color \_\_\_\_\_

Married \_\_\_\_\_

Single \_\_\_\_\_

Widow \_\_\_\_\_

Divorced \_\_\_\_\_

Married \_\_\_\_\_

Single \_\_\_\_\_

Widow \_\_\_\_\_

Divorced \_\_\_\_\_



## 0309 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>26 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>309 NORTH GREENE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>T</b> Last <b>GREEN</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 10, 1918</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DISHWASHER</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>41</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE T GREEN</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE GREEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW-11</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UNDIFFERENTIATED CARCINOMA MIDDLE EAR, RIGHT, WITH METASTASIS TO BRAIN</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>OTITIS MEDIA, CHRONIC</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>VA</b> attended the deceased from <b>December 14, 1959</b> , to <b>January 9, 1960</b> , and that death occurred on <b>January 9, 1960</b> , at <b>3:10 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Balto Md Ft Howard Div</b> DATE SIGNED <b>1-9-60</b>			
ACTUAL SIGNATURE <b>Charles Allen</b>		M.D. <b>VAH Balto Md Ft Howard Div</b> <b>1-9-60</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN</b>		M.D. <b>VAH BALTO MD FT HOWARD DIV.</b> <b>1-9-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/13/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 13 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Evans</b>

1808-10 N Monroe St, Baltimore 17, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
CERTIFICATE OF DEATH

NAME: [REDACTED] SEX: [REDACTED] AGE: [REDACTED]

DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]

DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]

DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]

DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]

DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]

DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

0310

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENCOE</b>				c. LENGTH OF STAY IN 1b <b>X</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENCOE ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>CLAY</b> Last <b>GROTON SR.</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 3, 1898</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTMASTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GLENCOE POST OFF. MARYLAND</b>			
13. FATHER'S NAME <b>WILLIAM T. GROTON</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA KATHERINE JOHNSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO YES</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE WWI 213-26-3238</b>			
17. INFORMANT <b>FAMILY RECORDS</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Aug 6 Jan</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>59</b> , to <b>Jan 15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 15</b> , 19 <b>60</b> , and that death occurred at <b>12</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Glenoe Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>R. Roy M. Polvogt</b> M.D. PHYSICIAN'S NAME (Type) <b>He Roy M. Polvogt</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>1/4/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>IMMUEL CHURCH CEMETERY</b>				22d. LOCATION (City, town, or county) (State) <b>GLENCOE MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 6 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

01883

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

MARYLAND

MARYLAND

MARYLAND

CLEARCREEK

CLEARCREEK

CLEARCREEK ROAD

CLEARCREEK ROAD

00

1

JANUARY

DECEMBER 31

DAY

THURSDAY

61

DECEMBER 1, 1908

1908

WHITE

MALE

124

CLEARCREEK ROAD, MARYLAND

MARYLAND

WILLIAM T. CROTON

NO. 123 - HIGH 101

MARYLAND

MARYLAND

MARYLAND CHURCH OF CHRIST

1/1/30

MARYLAND

## 0311 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>6 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>AGED WOMEN'S</u> OR INSTITUTION <u>615 Chestnut Ave Home</u>		d. STREET ADDRESS <u>1404 W. Lexington St</u>	
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>Louise</u> Last <u>Hagan</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3 1885</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>4</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>EUGENE HAGAN</u>		14. MOTHER'S MAIDEN NAME <u>ROSE GRUMBINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-30-8292A</u>	
17. INFORMANT <u>Florence Windsor Stewart</u>		Address <u>615 Chestnut Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Colon, Colostomy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 20, 1960</u> to <u>January 27, 1960</u> , that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland E. Day</u>		ADDRESS (Street, city or town, state) <u>4-8-33rd St - Balt, Md</u>	
PHYSICIAN'S NAME (Type) <u>Newland Edward Day MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-29-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. King</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1931

1430 Highland Ave. Boston, Mass.

3331 Main St. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.

1430 Highland Ave. Boston, Mass.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00291

<p>1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Carroll</b></p>	
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester, Box 81</b></p>	
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b></p>		<p>d. STREET ADDRESS <b>06x-2</b></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <b>William Raymond Hahn</b></p>		<p>4. DATE OF DEATH Month Day Year <b>1 9 1960</b></p>	
<p>5. SEX <b>M</b></p>	<p>6. COLOR OR RACE <b>W</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>3/3/1893</b></p>
<p>9. AGE (In years last birthday) <b>66 yrs.</b></p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>	<p>IF UNDER 24 HRS.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Md</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b></p>	
<p>13. FATHER'S NAME <b>Otto Hahn</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Nancy Harris</b></p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <b>None</b></p>	
<p>17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b></p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far Advanced Pulmonary Tuberculosis</b> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from <b>10/28</b>, 19<b>59</b>, to <b>1/9</b>, 19<b>60</b>, that I last saw the deceased alive on <b>1/9</b>, 19<b>60</b>, and that death occurred at <b>12:30 P.M.</b>, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED</p>			
<p>ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b></p>		<p>PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> Superintendent</p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>22b. DATE THEREOF <b>Jan 12-1960</b></p>	
<p>22c. NAME OF CEMETERY OR CREMATORY <b> Druid Ridge Cemetery</b></p>		<p>22d. LOCATION (City, town, or county) (State) <b>Pikesville Md</b></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Berryman &amp; Sons</b></p>		<p>ADDRESS <b>Reisterstown, Md</b></p>	
<p>24a. REC'D BY REGISTRAR DATE <b>JAN 12 '60</b></p>		<p>24b. REGISTRAR'S SIGNATURE <b>Charles L. Kinn</b></p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00292

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> <u>ROSEWOOD STATE TRAINING SCHOOL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>MARYLAND</u> COUNTY <u>ST. MARY COUNTY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS M.D.</u>		c. LENGTH OF STAY IN 1b <u>7 years 4 mo 11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD STATE TRAINING SCHOOL</u>		d. STREET ADDRESS <u>CALIFORNIA MARYLAND 18X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>WAYNE</u> Last <u>HARD</u>		4. DATE OF DEATH Month <u>1/23</u> Day <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/43</u>
9. AGE (In years lost birthday) <u>16 yrs.</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u>	11. IF UNDER 24 HRS. Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Paul Sullivan HARD</u>	
14. MOTHER'S MAIDEN NAME <u>HAZEL Blackwell HARD</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>90</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 22, 1960</u> to <u>Jan 23, 1960</u> that I last saw the deceased alive on <u>Jan 22, 1960</u> and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Harry S. Butler</u> M.D. <u>Owings Mills, Md 1/23/60</u>			
ACTUAL SIGNATURE <u>Harry S. Butler</u>			
PHYSICIAN'S NAME (Type) <u>Arthur S. Kraus</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 26, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oconee Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Oconee, South Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF DEATH

1968-1-1



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0314 CERTIFICATE OF DEATH

00293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1009 ALEXANDER AV.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>HARRIS</b> Last <b>(HARRIES)</b>				4. DATE OF DEATH Month <b>1</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-1892</b>		9. AGE (In years last birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PAPER MILL</b>		11. BIRTHPLACE (State or foreign country) <b>Longbranch, N.J.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>GEORGE HARRIS (HARRIES)</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE WASHINGTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. NETTIE H. PAGE (D)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>4210</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mitral Insufficiency</b> DUE TO (c) <b>Hypertensive Arterio-sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>82 days</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>CATONSVILLE</b>				20g. (County) <b>BALTO.</b>			
20h. (State) <b>MD.</b>							
21. I certify that I attended the deceased from <b>Oct-15th, 1959</b> , to <b>Jan. 5th, 1960</b> , that I last saw the deceased alive on <b>Jan. 5th, 1960</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C.F. Maloney</b>				ADDRESS (Street, city or town, state) <b>57 Winters Lane, Catonsville, 28. Md.</b>			
DATE SIGNED <b>Jan. 5. 60</b>							
PHYSICIAN'S NAME (Type) <b>C.F. Maloney, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM'L PK.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. Cooper</b>				ADDRESS <b>BALTO MD</b>		24a. REC'D BY REGISTRAR <b>JAN 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles G. Cooper</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>21. SIGNATURE OF MINISTRY</p>		<p>22. SIGNATURE OF OTHER</p>	
<p>23. SIGNATURE OF OTHER</p>		<p>24. SIGNATURE OF OTHER</p>	
<p>25. SIGNATURE OF OTHER</p>		<p>26. SIGNATURE OF OTHER</p>	
<p>27. SIGNATURE OF OTHER</p>		<p>28. SIGNATURE OF OTHER</p>	
<p>29. SIGNATURE OF OTHER</p>		<p>30. SIGNATURE OF OTHER</p>	
<p>31. SIGNATURE OF OTHER</p>		<p>32. SIGNATURE OF OTHER</p>	
<p>33. SIGNATURE OF OTHER</p>		<p>34. SIGNATURE OF OTHER</p>	
<p>35. SIGNATURE OF OTHER</p>		<p>36. SIGNATURE OF OTHER</p>	
<p>37. SIGNATURE OF OTHER</p>		<p>38. SIGNATURE OF OTHER</p>	
<p>39. SIGNATURE OF OTHER</p>		<p>40. SIGNATURE OF OTHER</p>	
<p>41. SIGNATURE OF OTHER</p>		<p>42. SIGNATURE OF OTHER</p>	
<p>43. SIGNATURE OF OTHER</p>		<p>44. SIGNATURE OF OTHER</p>	
<p>45. SIGNATURE OF OTHER</p>		<p>46. SIGNATURE OF OTHER</p>	
<p>47. SIGNATURE OF OTHER</p>		<p>48. SIGNATURE OF OTHER</p>	
<p>49. SIGNATURE OF OTHER</p>		<p>50. SIGNATURE OF OTHER</p>	
<p>51. SIGNATURE OF OTHER</p>		<p>52. SIGNATURE OF OTHER</p>	
<p>53. SIGNATURE OF OTHER</p>		<p>54. SIGNATURE OF OTHER</p>	
<p>55. SIGNATURE OF OTHER</p>		<p>56. SIGNATURE OF OTHER</p>	
<p>57. SIGNATURE OF OTHER</p>		<p>58. SIGNATURE OF OTHER</p>	
<p>59. SIGNATURE OF OTHER</p>		<p>60. SIGNATURE OF OTHER</p>	
<p>61. SIGNATURE OF OTHER</p>		<p>62. SIGNATURE OF OTHER</p>	
<p>63. SIGNATURE OF OTHER</p>		<p>64. SIGNATURE OF OTHER</p>	
<p>65. SIGNATURE OF OTHER</p>		<p>66. SIGNATURE OF OTHER</p>	
<p>67. SIGNATURE OF OTHER</p>		<p>68. SIGNATURE OF OTHER</p>	
<p>69. SIGNATURE OF OTHER</p>		<p>70. SIGNATURE OF OTHER</p>	
<p>71. SIGNATURE OF OTHER</p>		<p>72. SIGNATURE OF OTHER</p>	
<p>73. SIGNATURE OF OTHER</p>		<p>74. SIGNATURE OF OTHER</p>	
<p>75. SIGNATURE OF OTHER</p>		<p>76. SIGNATURE OF OTHER</p>	
<p>77. SIGNATURE OF OTHER</p>		<p>78. SIGNATURE OF OTHER</p>	
<p>79. SIGNATURE OF OTHER</p>		<p>80. SIGNATURE OF OTHER</p>	
<p>81. SIGNATURE OF OTHER</p>		<p>82. SIGNATURE OF OTHER</p>	
<p>83. SIGNATURE OF OTHER</p>		<p>84. SIGNATURE OF OTHER</p>	
<p>85. SIGNATURE OF OTHER</p>		<p>86. SIGNATURE OF OTHER</p>	
<p>87. SIGNATURE OF OTHER</p>		<p>88. SIGNATURE OF OTHER</p>	
<p>89. SIGNATURE OF OTHER</p>		<p>90. SIGNATURE OF OTHER</p>	
<p>91. SIGNATURE OF OTHER</p>		<p>92. SIGNATURE OF OTHER</p>	
<p>93. SIGNATURE OF OTHER</p>		<p>94. SIGNATURE OF OTHER</p>	
<p>95. SIGNATURE OF OTHER</p>		<p>96. SIGNATURE OF OTHER</p>	
<p>97. SIGNATURE OF OTHER</p>		<p>98. SIGNATURE OF OTHER</p>	
<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	



1 X  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>N.Y.</i> b. COUNTY <i>Bronx</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto. 7</i>	c. LENGTH OF STAY IN 1b <i>3 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New York 62 69X-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2820 Arlene Circle</i>		d. STREET ADDRESS <i>1521 Unionport Rd.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>KATHRYN L. HASSETT</i>		4. DATE OF DEATH <i>Jan 1 1960</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 12, 1885</i> AGE (In years birthday) <i>73</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Bronx N.Y.</i>
13. FATHER'S NAME <i>Wm Winkler</i>		14. MOTHER'S MAIDEN NAME <i>Marg. Healy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>va. H. Best.</i> Address <i>2820 Arlene Circle</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Angina Pectoris</i> <i>420.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>none</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>none</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D. D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES, M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan. 5, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>West Chester Co., New York</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i> ADDRESS <i>Ellsworth Armacost-4600 Liberty Hghts. Ave.</i>		24a. REC'D BY REGISTRAR <i>JAN 4 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00295

0316

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 Wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House In the Pines Conv. Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>M.</u> Last <u>Hayden</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Nov 1865</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Customs Insp. (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Treas. Dep't.</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown (Hayden)</u>		14. MOTHER'S MARDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Jesse Dunmuck</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Severe Arterio-sclerotic Atherosclerosis</u> (b) <u>Cardio-Vascular Disease</u> DUE TO <u>Cardio-Vascular Disease</u> (c) <u>Cardio-Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Semility</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 15, 1953</u> to <u>Jan 2, 1960</u> that I last saw the deceased alive on <u>Jan 2, 1960</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>M Paul Byerly</u> M.D.		PHYSICIAN'S NAME (Type) <u>M Paul Byerly</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5 Jan 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

---

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00296

0317

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3 v 01-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>45yr4mth15dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eleanore</u> Middle <u>Hennessey</u> Last <u>e</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>19 60</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 28, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>office worker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Michael Hennessey</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Doyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>		INFORMANT Address <u>Records; SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>Jan. 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 24</u> , 19 <u>60</u> , and that death occurred at <u>6:00M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>1-25-60</u> PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balts.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home, Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Date of death: \_\_\_\_\_

6. Place of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Date of registration: \_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0318

## CERTIFICATE OF DEATH

Reg. Dist. No.

00297

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6908 Windsor Mill Rd.</b>		d. STREET ADDRESS <b>6908 Windsor Mill Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George E. Henritz</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>17</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1885</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Henritz, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Subock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Maude M. Henritz</b>		Address <b>6908 Windsor Mill Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>DECEASED</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>*****</b>
20c. TIME OF INJURY Month, Day, Year <b>***** 19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>*****</b>
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January</b> , 19 <b>54</b> , to <b>January</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>13 January</b> , 19 <b>60</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5101 Gwynn Oak Ave</b> DATE SIGNED <b>1/18/60</b>			
ACTUAL SIGNATURE <b>Millard T. Traband, Jr.</b>		M.D. <b>5101 Gwynn Oak Ave</b>	
PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr.</b>		Baltimore, <b>7</b> , Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 20, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	
24a. REC'D BY REGISTRAR <b>JAN 19 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including date, time, place, and cause of death. The text is mostly illegible due to the quality of the scan.

Continuation of the death certificate form, containing fields for medical history, attending physician, and other relevant details. The text is mostly illegible due to the quality of the scan.

0319  
Baltimore County

CERTIFICATE OF DEATH

Reg. Dist. No.

00298

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b> c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Cntr. Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>614 N. HOWARD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY Joseph HENRY</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 30 1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 15 1879</b>
9. AGE (In years lost birthday) yrs. <b>80</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRANK B. HENRY</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE MADDEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>705 05 3103</b>	
17. INFORMANT <b>A-Mrs. Estelle H. Miller, 4416 Old Fredk. &amp;</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>CEREBRAL VASCULAR ACCIDENT</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>8 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 4</b> , 19 <b>59</b> , to <b>JAN 30</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JAN 30</b> , 19 <b>60</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francis T Daly</b>		ADDRESS (Street, city or town, state) <b>1725 RUSTERS TOWN PRISMALES</b>	
PHYSICIAN'S NAME (Type) <b>FRANCIS T THOMAS DALY</b>		DATE SIGNED <b>1/30/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 3/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. 29, Md.</b>	
23. FUNERAL DIRECTORS (Name and address) <b>Witke Funeral Directors 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Funn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000 05 2103 A-Mrs. Lucille H. Miller, wife of Fred H. J.

1010 Broadway Ave.  
New York, N.Y.  
Feb. 2, 1930  
Dear Sir:  
I am writing you to inform you that the  
above named person has been  
admitted to the  
New York State Bar Association  
and is now a member of the  
New York State Bar Association.  
Very truly yours,  
John J. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0320  
CERTIFICATE OF DEATH

00299

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Forest Haven Conv. Home</i>		d. STREET ADDRESS <i>3611 Helston Dr. 29</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Rachel L. Hildebrand</i> First Middle Last		4. DATE OF DEATH <i>Jan 28 1960</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/16/90</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Lueders</i>		14. MOTHER'S MAIDEN NAME <i>✓</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Linwood J. Tall</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial insufficiency</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>arterio sclerotic cardiovascular disease</i> DUE TO (c) <i>Diabetes mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Apr 8 1958</i> to <i>Jan 28 1960</i> , that (I) (we) last saw the deceased alive on <i>Jan 28 1960</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>George A. Knipp</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>George A. Knipp, M. D.</i>		22d. ADDRESS <i>4116 Edmondson Ave.,</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/1/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Indrabat + Don</i> ADDRESS <i>28</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 1 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	



0350

CERTIFICATE OF DEATH

0350

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00300

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>5 1/2 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen, n, Maryland</b> d. STREET ADDRESS <b>---- 55 Taft Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Danny</b> Middle <b>Hinckle</b> Last <b>Hinckle</b>		4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-19-59</b>
9. AGE (In years last birthday) <b>7</b>		IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min. <b>13</b>	IF UNDER 24 HRS. Min. <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-----</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David T. Hinckle</b>		14. MOTHER'S MAIDEN NAME <b>Shirley Frances Meadows</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
INFORMANT <b>Rosewood Records</b>		Address <b>344</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marked hydrocephalus and meningitis - myelocoe complicated by left purulent otitis media</b> 751x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO (c) <b>-----</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>			INTERVAL BETWEEN ONSET AND DEATH <b>-----</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>-----</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) (County) (State) <b>-----</b>
21. I certify that I attended the deceased from <b>-----</b> , 19 <b>-----</b> , to <b>-----</b> , 19 <b>-----</b> , that I last saw the deceased alive on <b>-----</b> , 19 <b>-----</b> , and that death occurred at <b>11:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. W. Rieckert</b>		ADDRESS (Street, city or town, state) <b>4307 Main Rd. Baltimore 14, Md.</b>	
PHYSICIAN'S NAME (Type) <b>P. W. Rieckert</b>		DATE SIGNED <b>2-3-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 4, 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Owings Mills, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

207122 3XUG

CERTIFICATE OF DEATH

1932

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of attending physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Date of registration: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G254 1-21-60 et

0322

## CERTIFICATE OF DEATH

Reg. Dist. No.

00301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Balto.</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Balto.</u>				c. LENGTH OF STAY IN 1b <u>Rural - Balto.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>609 Murdock Rd.</u>				d. STREET ADDRESS <u>609 Murdock Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Elizabeth</u> Middle <u>Hodes</u> Last <u>Hodes</u>				<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1862</u>	
9. AGE (In years last birthday) <u>97 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>John Hodes</u>				14. MOTHER'S MAIDEN NAME <u>Avelena Grieser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT Address <u>Margaret M. Hodes 609 Murdock Rd.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>  </u> DUE TO (b) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> o. m. <u>  </u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				(County) <u>  </u>		(State) <u>  </u>	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>54</u> to <u>Jan.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 14</u> , 19 <u>60</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm H Hammer</u> M.D.				ADDRESS (Street, city or town, state) <u>6011 York Rd. Balto. Md.</u>			
PHYSICIAN'S NAME (Type) <u>  </u>				DATE SIGNED <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 19, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins &amp; Sons Co.</u>				ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>							

CERTIFICATE OF DEATH

NAME: [illegible] NO. [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

DATE: Jan. 1, 1900

PLACE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0323 CERTIFICATE OF DEATH

Reg. Dist. No.

00302

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Baltimore.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Millers.</i>		c. LENGTH OF STAY IN 1b <i>50 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bollinger Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>E. Hoffman</i> Last <i>Hoffman</i>		4. DATE OF DEATH Month <i>January</i> Day <i>4</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1, 1884</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Cooper</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Williams.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>William H. Hoffman, Millers Md.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arterio-sclerosis</i> DUE TO (c) <i>hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 2</i> , 19 <i>60</i> , to <i>Jan 4</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan 2</i> , 19 <i>60</i> , and that death occurred at <i>3:40 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>A. M. France</i> M.D.		DATE SIGNED <i>1/4/60</i>	
PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>		<i>PARKTON, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 7, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Middletown Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Freeland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Dantenstein, New Freedom, Pa.</i>		24. REC'D BY REGISTRAR <i>JAN 6 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		DATE	

0030

0030 CERTIFICATE OF DEATH

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2530 Wentworth Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>2530 Wentworth Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Elsie G. Hogan</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4th</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1901</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS. Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>Annie G. Maxfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Mr. Joseph R. Hogan, Sr.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis</u> DUE TO (b) <u>~</u> DUE TO (c) <u>~</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19 <u>60</u> , to <u>Jan 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>60</u> , and that death occurred at <u>9:20 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold A Burns</u>		ADDRESS (Street, city or town, state) <u>8106 Harford Rd Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Harold Burns</u>		DATE <u>1-4-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REGISTRY SIGNATURE <u>JAN 6 '60</u>		24b. REGISTRY SIGNATURE <u>Arthur L. Kline</u>	

0322 CERTIFICATE OF DEATH

Baltimore

Baltimore

Baltimore

Female

Female

100 West Bond

100 West Bond

John P.

John P.

John P.

and wife

and wife

Married

Married

John P. and wife

John P. and wife

John P. and wife

## 0325 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alonzo</b> Middle <b>D.</b> Last <b>Holmes</b>				4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 2, 1886</b>	
9. AGE (In years lost birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>City of Baltimore</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George W. Holmes</b>				14. MOTHER'S MAIDEN NAME <b>Emily O'Neal</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>213-05-6821</b>			
17. INFORMANT <b>Clin. Records, Vet. Adm. Hosp. Balto, Md. Ft. Howard Div</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b> <b>465X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA PROSTATE</b> (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 5, 1960</b> to <b>January 17, 1960</b> and that death occurred at <b>7:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTIMORE, MD. FT HOWARD DIV. 1/17/60</b>							
ACTUAL SIGNATURE <b>MARTIN W. GOTTLIEB, M.D.</b> <b>VAH, BALTO. MD. FT HOWARD DIV 1/17/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/20/1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>				22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Katie Williams</b>				24a. REC'D BY REGISTRAR <b>JAN 20 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>William S. Kenna</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0325 CERTIFICATE OF DEATH

15 days

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0218 CERTIFICATE OF DEATH

Reg. Dist. No.

00305

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		c. LENGTH OF STAY IN 1b <u>364</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>307 Avondale Road</u>		e. STREET ADDRESS <u>307 Avondale Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie GARRIE Holmes</u>		4. DATE OF DEATH Month Day Year <u>January 24, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 21, 1905</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>3 2 25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Isle of Wight, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Clifton Joyner</u>		14. MOTHER'S MAIDEN NAME <u>Rosa E. Saunders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>915-22-5760</u>	
17. INFORMANT Address <u>Milton Holmes, 307 Avondale Rd. #22</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>605X Uremia</u> DUE TO <u>CYSTITIS, NEPHRITIS</u> DUE TO <u>CARCINOMA OF CERVIX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>2 YEARS</u> <u>1 YEAR 6 MOS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 1905</u> , 19 <u>59</u> , to <u>JAN 24, 1960</u> , that I last saw the deceased alive on <u>JAN 23, 1960</u> , and that death occurred at <u>6:30 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u>		ADDRESS (Street, city or town, state) <u>140 Oak Avenue</u> DATE SIGNED <u>1-24-60</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Jan 26/60</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Smithfield Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Milton E. Elchison</u>		ADDRESS <u>1129 N. Carroll St.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	
DATE <u>JAN 27 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 DEATH CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]	
SEX [Faint, illegible text]	
AGE [Faint, illegible text]	
DATE OF BIRTH [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]	
OCCUPATION [Faint, illegible text]	
CAUSE OF DEATH [Faint, illegible text]	
MANNER OF DEATH [Faint, illegible text]	
SIGNATURE OF PHYSICIAN [Faint, illegible text]	
SIGNATURE OF REGISTRAR [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]	
PLACE OF DEATH [Faint, illegible text]	
TIME OF DEATH [Faint, illegible text]	
SIGNATURE OF WITNESS [Faint, illegible text]	
SIGNATURE OF DECEASED [Faint, illegible text]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
 [Faint, illegible text]



0326 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>422 LAMBETH RD</u>		d. STREET ADDRESS <u>1422 LAMBETH RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE WARNER HORSEY</u>		4. DATE OF DEATH Month Day Year <u>JAN. 31 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 9, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry W. Warner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Boddy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Charles Horst - 422 Lambeth Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>416 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Rheumatic Heart Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>30-7 (7)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-16-</u> 19 <u>60</u> , to <u>1-31-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>1-30-</u> 19 <u>60</u> , and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Ave</u> <u>2-2-60</u> ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D. <u>Baltimore - 28</u> PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> <u>MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-4-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto</u> <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fairley Funeral Home - Catonsville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>English Consul</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 English Consul</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2730 Arbutus Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Melvin</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1886</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during months of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown Howard</u>				14. MOTHER'S MAIDEN NAME <u>don't know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Lillian Howard 2730 Arbutus Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Cardiovascular, arteriosclerotic disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. s. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. s. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 29 '60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sater's Cam.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC. 715 Light St.</u>				24a. REC'D BY REGISTRAR <u>JAN 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



0328

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradshaw</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradshaw</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reynolds Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A.</b> Last <b>Huber</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1879</b>		9. AGE (In years last birthday) yrs. <b>81</b>	10. IF UNDER 1 YEAR Months <b>25</b> Days <b>19</b> Hours <b>60</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Huber</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Debus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mrs. Katherine V. Chapman Reynolds Rd. Bradshaw, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO <b>Hypertension</b> (c) <b>14 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 2, 1948</b> to <b>Jan 25, 1960</b> that I last saw the deceased alive on <b>Jan 24, 1960</b> and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clifford F. Hudson</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>FORK, MD</b>			
PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-28-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Falls, Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Looman Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 27 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - WASHINGTON 10

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G254 1-8-60 et

00309

0329

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Gyro Dr</u>		d. STREET ADDRESS <u>14 Gyro Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>J.</u> Last <u>HULLER</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Martin Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Huller</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anna Klein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-20-6447</u>	
INFORMANT <u>Augusta E. Huller</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Cardiac decompensation, Terminal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced arteriosclerosis, generalized</u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN.</u> 19 <u>55</u> to <u>1/1</u> 19 <u>60</u> , that I last saw the deceased alive on <u>12/31</u> 19 <u>59</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1515 - Martin Blvd - R 1/4/60</u> DATE SIGNED ACTUAL SIGNATURE <u>Joseph J. Cameron</u> M.D. PHYSICIAN'S NAME (Type) <u>JOSEPH J. CAMERON</u> <u>Balto 20, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1-6-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>5305 Harford Rd</u> DATE <u>JAN 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

032

John A. Jones

77 years old

Married

for 15 years

Occupation

Teacher

John A. Jones

John A. Jones

John A. Jones

John A. Jones

John A. Jones

John A. Jones

John A. Jones

John A. Jones

John A. Jones

John A. Jones

John A. Jones

John A. Jones

Reg. Dist. No. 00310

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>20 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>(5) 3401-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1021 Rutland Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM HUTSON</b>		4. DATE OF DEATH Month Day Year <b>January 6 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1892</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>	11. BIRTHPLACE (State or foreign country) <b>Georgia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Nelson Hutson</b>	
14. MOTHER'S MAIDEN NAME <b>Alice MN: Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>	
16. SOCIAL SECURITY NO. <b>217-03-5013</b>		17. ADDRESS <b>Clin. Rec., Vet. Adm. Hosp. Balto. 18 Md. Ft. Howard</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BILATERAL CHRONIC PYELONEPHRITIS</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 17, 1959</b> to <b>January 6, 1960</b> that I last saw the deceased alive on <b>January 6, 1960</b> and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. 18, MD. FT HOWARD DIVISION 1/7/60</b>	
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, BALTO. 18, MD. FT HOWARD DIV. 1/7/60</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, BALTO. 18, MD. FT HOWARD DIV. 1/7/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		24a. REC'D BY REGISTRAR <b>JAN 13 60</b>	
24b. REGISTRAR'S SIGNATURE <b>W. L. T. T. T.</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
IS 15 9/58

CERTIFICATE OF DEATH

033

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
PLACE OF BIRTH  
DATE OF BIRTH  
SEX  
AGE  
OCCUPATION  
EDUCATION  
RELIGION  
MARRIAGE  
PREVIOUS ILLNESS  
PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL  
PREVIOUS TOBACCO  
PREVIOUS OTHER

1. Name of deceased: \_\_\_\_\_

2. Date of death: \_\_\_\_\_

3. Place of death: \_\_\_\_\_

4. Cause of death: \_\_\_\_\_

5. Manner of death: \_\_\_\_\_

6. Place of birth: \_\_\_\_\_

7. Date of birth: \_\_\_\_\_

8. Sex: \_\_\_\_\_

9. Age: \_\_\_\_\_

10. Occupation: \_\_\_\_\_

11. Education: \_\_\_\_\_

12. Religion: \_\_\_\_\_

13. Marriage: \_\_\_\_\_

14. Previous illness: \_\_\_\_\_

15. Previous surgery: \_\_\_\_\_

16. Previous trauma: \_\_\_\_\_

17. Previous drugs: \_\_\_\_\_

18. Previous alcohol: \_\_\_\_\_

19. Previous tobacco: \_\_\_\_\_

20. Previous other: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0331 CERTIFICATE OF DEATH

Reg. Dist. No. 00311

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7312 Dogwood Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7312 Dogwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RICHARD MORAN IRELAND</b>		4. DATE OF DEATH Month Day Year <b>January 18 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1885</b>
9. AGE (In years lost birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-3675</b>	
17. INFORMANT <b>Elizabeth Ireland-7312 Dogwood Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory failure</b> DUE TO (b) <b>Dehydration + malnutrition</b> DUE TO (c) <b>Carcinoma of pancreas</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1959</b> to <b>18 Jan 1960</b> , that I last saw the deceased alive on <b>18 Jan 1960</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>William J. Bryson</b> M.D. <b>4605 Edmondson Ave</b> <b>19 Jan 60</b> PHYSICIAN'S NAME (Type) <b>William J. Bryson, M.D.</b> <b>4605 Edmondson Ave.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/21/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elizabeth Ireland</b> ADDRESS <b>4600 Liberty Heights Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G254 1-18-60 et

0332

CERTIFICATE OF DEATH

00312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY— <b>Balto.City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgmeere</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.City</b> 3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8102 Rosebank Ave. (Private home)</b>		d. STREET ADDRESS <b>803 N. Augusta Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Lena Jankiewicz</b>		4. DATE OF DEATH <b>January 11, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wojciech Spioch</b>		14. MOTHER'S MAIDEN NAME <b>Justina Jacinty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Joseph A. Jankiewicz</b>		Address <b>1713 Eastern Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cecum - metastasis</b> <b>153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 1959</b> to <b>Jan 11, 1960</b> , that I last saw the deceased alive on <b>Jan 11, 1959</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2002 E. Rutland Balto. 31-Md.</b> DATE SIGNED <b>1/11/60</b>			
ACTUAL SIGNATURE <b>Israel J. Feinglos</b> M.D.			
PHYSICIAN'S NAME (Type) <b>ISRAEL J. FEINGLOS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		22d. LOCATION (City, town, or county) (State) <b>Balto.Co.Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. S. Fialkowski</b>		ADDRESS <b>2007 Eastern Ave.</b>	
24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0219

## CERTIFICATE OF DEATH

00313

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk 22</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7822 St. Fabians Lane</b>				d. STREET ADDRESS <b>7822 St. Fabians Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Louis</b> Last <b>Jenkins</b>				4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1894</b>		9. AGE (In years last birthday) yrs. <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cross &amp; Blackwell</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES W W I</b>				16. SOCIAL SECURITY NO. <b>217-05-5525</b>		17. INFORMANT Address <b>Mrs. Pearl M. Jenkins, 7822 St. Fabians Lane</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary Carcinoma of lung -</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug. 29, 1959</b> , to <b>Jan. 7, 1960</b> , that I last saw the deceased alive on <b>Jan. 7, 1960</b> , and that death occurred at <b>2:35 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore 24, Maryland.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Manuel P. de Leon</b> M.D.							
PHYSICIAN'S NAME (Type) <b>MANUEL P DE LEON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-11-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0518 CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. PLACE OF BIRTH	
11. SEX		12. AGE	
13. OCCUPATION		14. CAUSE OF DEATH	
15. DATE OF DEATH		16. TIME OF DEATH	
17. PLACE OF DEATH		18. PLACE OF BIRTH	
19. SEX		20. AGE	
21. OCCUPATION		22. CAUSE OF DEATH	
23. DATE OF DEATH		24. TIME OF DEATH	
25. PLACE OF DEATH		26. PLACE OF BIRTH	
27. SEX		28. AGE	
29. OCCUPATION		30. CAUSE OF DEATH	
31. DATE OF DEATH		32. TIME OF DEATH	
33. PLACE OF DEATH		34. PLACE OF BIRTH	
35. SEX		36. AGE	
37. OCCUPATION		38. CAUSE OF DEATH	
39. DATE OF DEATH		40. TIME OF DEATH	
41. PLACE OF DEATH		42. PLACE OF BIRTH	
43. SEX		44. AGE	
45. OCCUPATION		46. CAUSE OF DEATH	
47. DATE OF DEATH		48. TIME OF DEATH	
49. PLACE OF DEATH		50. PLACE OF BIRTH	
51. SEX		52. AGE	
53. OCCUPATION		54. CAUSE OF DEATH	
55. DATE OF DEATH		56. TIME OF DEATH	
57. PLACE OF DEATH		58. PLACE OF BIRTH	
59. SEX		60. AGE	
61. OCCUPATION		62. CAUSE OF DEATH	
63. DATE OF DEATH		64. TIME OF DEATH	
65. PLACE OF DEATH		66. PLACE OF BIRTH	
67. SEX		68. AGE	
69. OCCUPATION		70. CAUSE OF DEATH	
71. DATE OF DEATH		72. TIME OF DEATH	
73. PLACE OF DEATH		74. PLACE OF BIRTH	
75. SEX		76. AGE	
77. OCCUPATION		78. CAUSE OF DEATH	
79. DATE OF DEATH		80. TIME OF DEATH	
81. PLACE OF DEATH		82. PLACE OF BIRTH	
83. SEX		84. AGE	
85. OCCUPATION		86. CAUSE OF DEATH	
87. DATE OF DEATH		88. TIME OF DEATH	
89. PLACE OF DEATH		90. PLACE OF BIRTH	
91. SEX		92. AGE	
93. OCCUPATION		94. CAUSE OF DEATH	
95. DATE OF DEATH		96. TIME OF DEATH	
97. PLACE OF DEATH		98. PLACE OF BIRTH	
99. SEX		100. AGE	
101. OCCUPATION		102. CAUSE OF DEATH	
103. DATE OF DEATH		104. TIME OF DEATH	
105. PLACE OF DEATH		106. PLACE OF BIRTH	
107. SEX		108. AGE	
109. OCCUPATION		110. CAUSE OF DEATH	
111. DATE OF DEATH		112. TIME OF DEATH	
113. PLACE OF DEATH		114. PLACE OF BIRTH	
115. SEX		116. AGE	
117. OCCUPATION		118. CAUSE OF DEATH	
119. DATE OF DEATH		120. TIME OF DEATH	
121. PLACE OF DEATH		122. PLACE OF BIRTH	
123. SEX		124. AGE	
125. OCCUPATION		126. CAUSE OF DEATH	
127. DATE OF DEATH		128. TIME OF DEATH	
129. PLACE OF DEATH		130. PLACE OF BIRTH	
131. SEX		132. AGE	
133. OCCUPATION		134. CAUSE OF DEATH	
135. DATE OF DEATH		136. TIME OF DEATH	
137. PLACE OF DEATH		138. PLACE OF BIRTH	
139. SEX		140. AGE	
141. OCCUPATION		142. CAUSE OF DEATH	
143. DATE OF DEATH		144. TIME OF DEATH	
145. PLACE OF DEATH		146. PLACE OF BIRTH	
147. SEX		148. AGE	
149. OCCUPATION		150. CAUSE OF DEATH	
151. DATE OF DEATH		152. TIME OF DEATH	
153. PLACE OF DEATH		154. PLACE OF BIRTH	
155. SEX		156. AGE	
157. OCCUPATION		158. CAUSE OF DEATH	
159. DATE OF DEATH		160. TIME OF DEATH	
161. PLACE OF DEATH		162. PLACE OF BIRTH	
163. SEX		164. AGE	
165. OCCUPATION		166. CAUSE OF DEATH	
167. DATE OF DEATH		168. TIME OF DEATH	
169. PLACE OF DEATH		170. PLACE OF BIRTH	
171. SEX		172. AGE	
173. OCCUPATION		174. CAUSE OF DEATH	
175. DATE OF DEATH		176. TIME OF DEATH	
177. PLACE OF DEATH		178. PLACE OF BIRTH	
179. SEX		180. AGE	
181. OCCUPATION		182. CAUSE OF DEATH	
183. DATE OF DEATH		184. TIME OF DEATH	
185. PLACE OF DEATH		186. PLACE OF BIRTH	
187. SEX		188. AGE	
189. OCCUPATION		190. CAUSE OF DEATH	
191. DATE OF DEATH		192. TIME OF DEATH	
193. PLACE OF DEATH		194. PLACE OF BIRTH	
195. SEX		196. AGE	
197. OCCUPATION		198. CAUSE OF DEATH	
199. DATE OF DEATH		200. TIME OF DEATH	
201. PLACE OF DEATH		202. PLACE OF BIRTH	
203. SEX		204. AGE	
205. OCCUPATION		206. CAUSE OF DEATH	
207. DATE OF DEATH		208. TIME OF DEATH	
209. PLACE OF DEATH		210. PLACE OF BIRTH	
211. SEX		212. AGE	
213. OCCUPATION		214. CAUSE OF DEATH	
215. DATE OF DEATH		216. TIME OF DEATH	
217. PLACE OF DEATH		218. PLACE OF BIRTH	
219. SEX		220. AGE	
221. OCCUPATION		222. CAUSE OF DEATH	
223. DATE OF DEATH		224. TIME OF DEATH	
225. PLACE OF DEATH		226. PLACE OF BIRTH	
227. SEX		228. AGE	
229. OCCUPATION		230. CAUSE OF DEATH	
231. DATE OF DEATH		232. TIME OF DEATH	
233. PLACE OF DEATH		234. PLACE OF BIRTH	
235. SEX		236. AGE	
237. OCCUPATION		238. CAUSE OF DEATH	
239. DATE OF DEATH		240. TIME OF DEATH	
241. PLACE OF DEATH		242. PLACE OF BIRTH	
243. SEX		244. AGE	
245. OCCUPATION		246. CAUSE OF DEATH	
247. DATE OF DEATH		248. TIME OF DEATH	
249. PLACE OF DEATH		250. PLACE OF BIRTH	
251. SEX		252. AGE	
253. OCCUPATION		254. CAUSE OF DEATH	
255. DATE OF DEATH		256. TIME OF DEATH	
257. PLACE OF DEATH		258. PLACE OF BIRTH	
259. SEX		260. AGE	
261. OCCUPATION		262. CAUSE OF DEATH	
263. DATE OF DEATH		264. TIME OF DEATH	
265. PLACE OF DEATH		266. PLACE OF BIRTH	
267. SEX		268. AGE	
269. OCCUPATION		270. CAUSE OF DEATH	
271. DATE OF DEATH		272. TIME OF DEATH	
273. PLACE OF DEATH		274. PLACE OF BIRTH	
275. SEX		276. AGE	
277. OCCUPATION		278. CAUSE OF DEATH	
279. DATE OF DEATH		280. TIME OF DEATH	
281. PLACE OF DEATH		282. PLACE OF BIRTH	
283. SEX		284. AGE	
285. OCCUPATION		286. CAUSE OF DEATH	
287. DATE OF DEATH		288. TIME OF DEATH	
289. PLACE OF DEATH		290. PLACE OF BIRTH	
291. SEX		292. AGE	
293. OCCUPATION		294. CAUSE OF DEATH	
295. DATE OF DEATH		296. TIME OF DEATH	
297. PLACE OF DEATH		298. PLACE OF BIRTH	
299. SEX		300. AGE	
301. OCCUPATION		302. CAUSE OF DEATH	
303. DATE OF DEATH		304. TIME OF DEATH	
305. PLACE OF DEATH		306. PLACE OF BIRTH	
307. SEX		308. AGE	
309. OCCUPATION		310. CAUSE OF DEATH	
311. DATE OF DEATH		312. TIME OF DEATH	
313. PLACE OF DEATH		314. PLACE OF BIRTH	
315. SEX		316. AGE	
317. OCCUPATION		318. CAUSE OF DEATH	
319. DATE OF DEATH		320. TIME OF DEATH	
321. PLACE OF DEATH		322. PLACE OF BIRTH	
323. SEX		324. AGE	
325. OCCUPATION		326. CAUSE OF DEATH	
327. DATE OF DEATH		328. TIME OF DEATH	
329. PLACE OF DEATH		330. PLACE OF BIRTH	
331. SEX		332. AGE	
333. OCCUPATION		334. CAUSE OF DEATH	
335. DATE OF DEATH		336. TIME OF DEATH	
337. PLACE OF DEATH		338. PLACE OF BIRTH	
339. SEX		340. AGE	
341. OCCUPATION		342. CAUSE OF DEATH	
343. DATE OF DEATH		344. TIME OF DEATH	
345. PLACE OF DEATH		346. PLACE OF BIRTH	
347. SEX		348. AGE	
349. OCCUPATION		350. CAUSE OF DEATH	
351. DATE OF DEATH		352. TIME OF DEATH	
353. PLACE OF DEATH		354. PLACE OF BIRTH	
355. SEX		356. AGE	
357. OCCUPATION		358. CAUSE OF DEATH	
359. DATE OF DEATH		360. TIME OF DEATH	
361. PLACE OF DEATH		362. PLACE OF BIRTH	
363. SEX		364. AGE	
365. OCCUPATION		366. CAUSE OF DEATH	
367. DATE OF DEATH		368. TIME OF DEATH	
369. PLACE OF DEATH		370. PLACE OF BIRTH	
371. SEX		372. AGE	
373. OCCUPATION		374. CAUSE OF DEATH	
375. DATE OF DEATH		376. TIME OF DEATH	
377. PLACE OF DEATH		378. PLACE OF BIRTH	
379. SEX		380. AGE	
381. OCCUPATION		382. CAUSE OF DEATH	
383. DATE OF DEATH		384. TIME OF DEATH	
385. PLACE OF DEATH		386. PLACE OF BIRTH	
387. SEX		388. AGE	
389. OCCUPATION		390. CAUSE OF DEATH	
391. DATE OF DEATH		392. TIME OF DEATH	
393. PLACE OF DEATH		394. PLACE OF BIRTH	
395. SEX		396. AGE	
397. OCCUPATION		398. CAUSE OF DEATH	
399. DATE OF DEATH		400. TIME OF DEATH	
401. PLACE OF DEATH		402. PLACE OF BIRTH	
403. SEX		404. AGE	
405. OCCUPATION		406. CAUSE OF DEATH	
407. DATE OF DEATH		408. TIME OF DEATH	
409. PLACE OF DEATH		410. PLACE OF BIRTH	
411. SEX		412. AGE	
413. OCCUPATION		414. CAUSE OF DEATH	
415. DATE OF DEATH		416. TIME OF DEATH	
417. PLACE OF DEATH		418. PLACE OF BIRTH	
419. SEX		420. AGE	
421. OCCUPATION		422. CAUSE OF DEATH	
423. DATE OF DEATH		424. TIME OF DEATH	
425. PLACE OF DEATH		426. PLACE OF BIRTH	
427. SEX		428. AGE	
429. OCCUPATION		430. CAUSE OF DEATH	
431. DATE OF DEATH		432. TIME OF DEATH	
433. PLACE OF DEATH		434. PLACE OF BIRTH	
435. SEX		436. AGE	
437. OCCUPATION		438. CAUSE OF DEATH	
439. DATE OF DEATH		440. TIME OF DEATH	
441. PLACE OF DEATH		442. PLACE OF BIRTH	
443. SEX		444. AGE	
445. OCCUPATION		446. CAUSE OF DEATH	
447. DATE OF DEATH		448. TIME OF DEATH	
449. PLACE OF DEATH		450. PLACE OF BIRTH	
451. SEX		452. AGE	
453. OCCUPATION		454. CAUSE OF DEATH	
455. DATE OF DEATH		456. TIME OF DEATH	
457. PLACE OF DEATH		458. PLACE OF BIRTH	
459. SEX		460. AGE	
461. OCCUPATION		462. CAUSE OF DEATH	
463. DATE OF DEATH		464. TIME OF DEATH	
465. PLACE OF DEATH		466. PLACE OF BIRTH	
467. SEX		468. AGE	
469. OCCUPATION		470. CAUSE OF DEATH	
471. DATE OF DEATH		472. TIME OF DEATH	
473. PLACE OF DEATH		474. PLACE OF BIRTH	
475. SEX		476. AGE	
477. OCCUPATION		478. CAUSE OF DEATH	
479. DATE OF DEATH		480. TIME OF DEATH	
481. PLACE OF DEATH		482. PLACE OF BIRTH	
483. SEX		484. AGE	
485. OCCUPATION		486. CAUSE OF DEATH	
487. DATE OF DEATH		488. TIME OF DEATH	
489. PLACE OF DEATH		490. PLACE OF BIRTH	
491. SEX		492. AGE	
493. OCCUPATION		494. CAUSE OF DEATH	
495. DATE OF DEATH		496. TIME OF DEATH	
497. PLACE OF DEATH		498. PLACE OF BIRTH	
499. SEX		500. AGE	
501. OCCUPATION		502. CAUSE OF DEATH	
503. DATE OF DEATH		504. TIME OF DEATH	
505. PLACE OF DEATH		506. PLACE OF BIRTH	
507. SEX		508. AGE	
509. OCCUPATION		510. CAUSE OF DEATH	
511. DATE OF DEATH		512. TIME OF DEATH	
513. PLACE OF DEATH		514. PLACE OF BIRTH	
515. SEX		516. AGE	
517. OCCUPATION		518. CAUSE OF DEATH	
519. DATE OF DEATH		520. TIME OF DEATH	
521. PLACE OF DEATH		522. PLACE OF BIRTH	
523. SEX		524. AGE	
525. OCCUPATION		526. CAUSE OF DEATH	
527. DATE OF DEATH		528. TIME OF DEATH	
529. PLACE OF DEATH		530. PLACE OF BIRTH	
531. SEX		532. AGE	
533. OCCUPATION		534. CAUSE OF DEATH	
535. DATE OF DEATH		536. TIME OF DEATH	
537. PLACE OF DEATH		538. PLACE OF BIRTH	
539. SEX		540. AGE	
541. OCCUPATION		542. CAUSE OF DEATH	
543. DATE OF DEATH		544. TIME OF DEATH	
545. PLACE OF DEATH		546. PLACE OF BIRTH	
547. SEX		548. AGE	
549. OCCUPATION		550. CAUSE OF DEATH	
551. DATE OF DEATH		552. TIME OF DEATH	
553. PLACE OF DEATH		554. PLACE OF BIRTH	
555. SEX		556. AGE	
557. OCCUPATION		558. CAUSE OF DEATH	
559. DATE OF DEATH		560. TIME OF DEATH	
561. PLACE OF DEATH		562. PLACE OF BIRTH	
563. SEX		564. AGE	
565. OCCUPATION		566. CAUSE OF DEATH	
567. DATE OF DEATH		568. TIME OF DEATH	
569. PLACE OF DEATH		570. PLACE OF BIRTH	
571. SEX		572. AGE	
573. OCCUPATION		574. CAUSE OF DEATH	
575. DATE OF DEATH		576. TIME OF DEATH	
577. PLACE OF DEATH		578. PLACE OF BIRTH	
579. SEX		580. AGE	
581. OCCUPATION		582. CAUSE OF DEATH	
583. DATE OF DEATH		584. TIME OF DEATH	
585. PLACE OF DEATH		586. PLACE OF BIRTH	
587. SEX		588. AGE	
589. OCCUPATION		590. CAUSE OF DEATH	
591. DATE OF DEATH		592. TIME OF DEATH	
593. PLACE OF DEATH		594. PLACE OF BIRTH	
595. SEX		596. AGE	
597. OCCUPATION		598. CAUSE OF DEATH	
599. DATE OF DEATH		600. TIME OF DEATH	
601. PLACE OF DEATH		602. PLACE OF BIRTH	
603. SEX		604. AGE	
605. OCCUPATION		606. CAUSE OF DEATH	
607. DATE OF DEATH		608. TIME OF DEATH	
609. PLACE OF DEATH		610. PLACE OF BIRTH	
611. SEX		612. AGE	
613. OCCUPATION		614. CAUSE OF DEATH	
615. DATE OF DEATH		616. TIME OF DEATH	
617. PLACE OF DEATH		618. PLACE OF BIRTH	
619. SEX		620. AGE	
621. OCCUPATION		622. CAUSE OF DEATH	
623. DATE OF DEATH		624. TIME OF DEATH	
625. PLACE OF DEATH		626. PLACE OF BIRTH	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0333 Item 2 Film 254 1-21-60 et  
**CERTIFICATE OF DEATH**

00314

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Penn.</i> b. COUNTY <i>Blacksburg?</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calonsville</i>		c. LENGTH OF STAY IN 1b <i>8 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Summit Conv. Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joy</i> Middle <i>Jones</i> Last <i>Jones</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/8/70</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Freeland Md.</i>
13. FATHER'S NAME <i>Edward Wincholt</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Keeney</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Hospital records</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Terminal Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i> (c) <i>Generalized Arterio Sclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1955</i> to <i>1/14/60</i> , that (I) <i>last</i> saw the deceased alive on <i>1/13/60</i> , and that death occurred <i>130P</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.E. McGrath M.D.</i>		22b. DATE SIGNED <i>1/14/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.E. McGrath M.D.</i>		22d. ADDRESS <i>1303 Frederick Rd (28)</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Jan. 18, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Stiltz Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Glen Rock Pa. R.D. 3.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Hostenstein</i>		25a. REC'D BY REGISTRAR <i>DATE JAN 19 '60</i>	
ADDRESS <i>New Freedom, Pa.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

*McGrath & Son Calonsville Md*



1031

UNITED STATES DEPARTMENT OF HEALTH  
OFFICE OF VITAL STATISTICS  
CERTIFICATE OF DEATH

0333

*[Faint, mostly illegible text from the reverse side of the document, including names and dates.]*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00315

0334

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point, Md.</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sparrows Point, Md.</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Hospital</u>				d. STREET ADDRESS <u>1005 "K" St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Eddie</u> Middle <u>(n)</u> Last <u>Jordan</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>61 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Skill Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Smithfield Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Hollaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-2571</u>		17. INFORMANT <u>Frank Jordan 1523 McKeen Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular dis.</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Jack C. Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gamble Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Smithfield Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. G. Wilson 1000 Brantley</u>				24a. REC'D BY REGISTRAR <u>Jan 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00316  
32

0335

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO CITY</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN TB <b>1 1/2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WALTER</b> Last <b>JURKOWSKI</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/17</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANK JURKOWSKI</b>	
14. MOTHER'S MAIDEN NAME <b>MARIANNE FRECHTEL</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>214-03-2090</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____			INTERVAL BETWEEN ONSET AND DEATH <b>7 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/24</b> , 19 <b>58</b> , to <b>1-3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-3</b> , 19 <b>60</b> , and that death occurred at <b>2:45</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED _____ ACTUAL SIGNATURE _____ PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-7-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM</b>	22d. LOCATION (City, town, or county) (State) <b>6515 BOSTON ST. BALTO., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Giller</b> ADDRESS <b>9015 CONKLING ST. BALTO. 24 MD</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 8 1960</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH OF <b>WILLIAM BROWN</b> DATE OF DEATH <b>1912</b> PLACE OF DEATH <b>HOME</b>		DEATH OF <b>WILLIAM BROWN</b> DATE OF DEATH <b>1912</b> PLACE OF DEATH <b>HOME</b>	
SEX <b>MALE</b> AGE <b>45</b> OCCUPATION <b>LABORER</b>		SEX <b>MALE</b> AGE <b>45</b> OCCUPATION <b>LABORER</b>	
BIRTH <b>1867</b> PLACE OF BIRTH <b>MD</b>		BIRTH <b>1867</b> PLACE OF BIRTH <b>MD</b>	
CAUSE OF DEATH <b>HEART DISEASE</b> MANNER OF DEATH <b>NATURAL</b>		CAUSE OF DEATH <b>HEART DISEASE</b> MANNER OF DEATH <b>NATURAL</b>	
SIGNATURE OF PHYSICIAN <b>W. B. BROWN</b> DATE <b>1912</b>		SIGNATURE OF PHYSICIAN <b>W. B. BROWN</b> DATE <b>1912</b>	
SIGNATURE OF DEATH REGISTRAR <b>W. B. BROWN</b> DATE <b>1912</b>		SIGNATURE OF DEATH REGISTRAR <b>W. B. BROWN</b> DATE <b>1912</b>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00317

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">0336</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>50 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b> d. STREET ADDRESS <b>6402 Pratt Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>D.</b> Last <b>Kahler</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 1, 1869</b>
9. AGE (In years last birthday) <b>90 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>	11. BIRTHPLACE (State or foreign country) <b>York, Penna.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Henry Weaver</b>	
14. MOTHER'S MAIDEN NAME <b>Matilda Schroeder</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. J. C. Anderson 6402 Pratt Ave Balt. 12</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Sudden</b> (c) <b>Interval between onset and death</b> DUE TO <b>underlying cause lost.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		DATE SIGNED <b>1/8/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. Weaver - Son 805 N. Calvert St.</b>		24a. REC'D BY REGISTRAR <b>JAN 11 1960</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







# 1 094 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death. 033 00318 Reg. Dist. No. 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Towson d. STREET ADDRESS Glenarm Road e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ 3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Constantine Kirchner 4. DATE OF DEATH Month Day Year January 31 19 60 5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH October 19, 1884 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Michael Kirchner 14. MOTHER'S MAIDEN NAME Cunigunda Loeffler 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Sister M. Peter Fourier Notch Cliff, Md. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Hypertensive Cardio- Renal Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☐ at work ☐ of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from May 19 58, to Jan. 19 60, that I last saw the deceased alive on January 26, 19 60, and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles F. O'Donnell 7501 York Road Towson 4, Md. 1/31/60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 2-2-60, VILLA MARIA CEM NOTCH CLIFF NR TOWSON, MD. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles S. Guler 901 S. CONKLING ST. BALTO, 24, MD 24a. REC'D BY REGISTRAR DATE FEB 2 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

10

## 0338 CERTIFICATE OF DEATH

Reg. Dist. No.

00319

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>39 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>(1) 3401-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3 West Preston Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>E.</b> Last <b>KNABE</b>			4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 2, 1925</b>		9. AGE (In years lost birthday) <b>34</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>William E. Knabe</b>			14. MOTHER'S MAIDEN NAME <b>Emma P. Eisenlohr</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 218-12-0654</b>		INFORMANT <b>Clin. Rec., Vet. Adm. Hosp. Balto. 18, Md. Ft. Howard Div.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CEREBRAL INFARCT, RIGHT HEMISPHERE</b> DUE TO <b>THROMBOSIS OF RIGHT INTERNAL CAROTIC ARTERY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>OLD MYOCARDIAL INFARCTION</b> <b>GENERALIZED ARTERIOSCLEROSIS, MARKED</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>2 DAYS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple Sclerosis</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 4, 19 59</b> to <b>January 12, 1960</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Balto. 18, Md. Ft. Howard Division</b> DATE SIGNED <b>1/13/60</b> ACTUAL SIGNATURE <b>John E. Crawford</b> M.D. <b>VAH, Balto. 18, Md. Ft. Howard Division</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, Balto. 18, Md. Ft. Howard Div.</b> <b>1/13/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-15-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc. 6009 Harford Rd. Balto. 14, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 19 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0201168

WILEY

10. *Psychiatry* 5, 200 (1971).

© 1996 by The McGraw-Hill Companies

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

William E. Knappe

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-10-2001 BY 60322 UCBAW

WITNOLD HILGEMANN, MD

electronic photo

1. 2000

[illegible]

U.S. DEPARTMENT OF COMMERCE

0339

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr7mth2dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Essa</b> Middle <b>June</b> Last <b>Knauff</b>				4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1881</b>	9. AGE (In years lost birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>sewing factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Milton Lewis Belleson</b>				14. MOTHER'S MAIDEN NAME <b>CLARISSA Clarine Willis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-20-6820</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 7, 1960</b> to <b>Jan. 19, 1960</b> , that I last saw the deceased alive on <b>Jan. 19, 1960</b> , and that death occurred at <b>8:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachler</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 1-19-60</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1'22'60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Avenue</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 22 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1010 Harrison Ave.

NEW YORK

1910

1010 Harrison Ave.

Howard H. Robinson 4107 Wilkerson Avenue  
1910

London Park Cemetery, Baltimore, Maryland



# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G255 2-1-60 et

00321

034

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STONELEIGH</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STONELEIGH</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6901 MARLBOROUGH, RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER A. KOLPACK</b>				4. DATE OF DEATH Month Day Year <b>JAN 2 1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 20, 1889</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTO DEALER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>HOWARD, CO.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>FRANK KOLPACK</b>				14. MOTHER'S MAIDEN NAME <b>Renee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>219-28-4061</b>			
17. INFORMANT <b>Mrs LOTTIE C. KOLPACK.</b>				18. ADDRESS <b>SAME.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>10 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 46</b> to <b>Jan 60</b> that I last saw the deceased alive on <b>Jan 60</b> , and that death occurred at <b>1030 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles H. Keier</b> M.D.				ADDRESS (Street, city or town, state) <b>6701 York Rd Balto Md</b>			
PHYSICIAN'S NAME (Type) <b>Charles H. Keier</b>				DATE SIGNED <b>4 Jan 60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>1-6-60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>WESTERN CEMETERY</b>				22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY W. JENKINS &amp; SONS, CO.</b>				ADDRESS <b>4905 YORK, RD.</b>			
24a. REC'D BY REGISTRAR <b>JAN 6 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1903

DEATH CERTIFICATE

63

MARYLAND

BALTIMORE

STONELEIGH

STONELEIGH

61 MARLBOROUGH RD. BALTIMORE, MD.

WALTER A. KILPATRICK

MALE WHITE

Auto Dealer, Revised, Co. U.S.A.

FRANK A. KILPATRICK

219-28-4001A Mrs. Lillian C. Kilpatrick

Western Cemetery  
Baltimore, Md.

Henry W. Jenkins & Sons, 4101 York Road, Baltimore, Md.  
Buried in Western Cemetery, Baltimore, Md.  
Charles H. Teller  
of 1111 York Road, Baltimore, Md.  
at 10:30 A.M. on Jan. 2, 1903.

## 0341 CERTIFICATE OF DEATH

Reg. Dist. No.

00322

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> M X b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 W. Elm Ave</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> X d. STREET ADDRESS <b>101 W. Elm Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>R.</b> Last <b>Kornmann</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1960</b> IX			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 3-1886</b>	
9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>	
13. FATHER'S NAME <b>John Norris</b>				14. MOTHER'S MAIDEN NAME <b>Rose Worth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		INFORMANT Address <b>Melvin Kornmann 101 W. Elm Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <b>Hyper-tensive atherosclerotic</b> DUE TO <b>Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Cardiovascular Disease</b> DUE TO (c) <b>Cardiovascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>inlet</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypo thyroidism</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Spring</b> , 1957, to <b>Jun 31</b> , 1960, that I last saw the deceased alive on <b>28 Jun</b> , 1960, and that death occurred at <b>4:54 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7527 Belair Rd</b> DATE SIGNED <b>2-2-60</b>							
ACTUAL SIGNATURE <b>John C. Hyle</b>		M.D. <b>7527 Belair Rd</b>					
PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-3-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Pk. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Josephine H. Hyle</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 3 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hyle</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

0032

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of registrar: [illegible]  
9. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0342 CERTIFICATE OF DEATH

00323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Baltimore)</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>304 Overbrook Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>M.</b> Last <b>Krause</b>				4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>19 60</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/27/1881</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John J. Krause</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Unkelbach</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mabel E. Krause (Above)</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>DIABETES MELLITUS</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>8 yrs.</b> <b>6 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec 29</b> , 19 <b>59</b> , to <b>Jan 26</b> , 19 <b>60</b> , that I lost saw the deceased alive on <b>Jan 26</b> , 19 <b>60</b> , and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6210 York Rd Baltimore 18, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>A.S. Chalfant</b>				M.D. <b>6210 York Rd Baltimore 18, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. A.S. CHALFANT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co. - 4905 York Rd. Balto. 12.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

M

I

0

1

DP





## CERTIFICATE OF DEATH

Reg. Dist. No.

00324

0343

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. LENGTH OF STAY IN 1b <b>??</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XX Baltimore 23</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Warren Road</b>				d. STREET ADDRESS <b>22 N. Ashburton St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Amelia Hess Krout</b>		First Middle Last		4. DATE OF DEATH <b>1-27-60</b>		Month Day Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-4-1870</b>		9. AGE (In years last birthday) yrs. <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Hess</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Leister</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		INFORMANT Address <b>Russell I. Krout, Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma Lt. Breast</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-27-1938</b> to <b>1-27-1960</b> that I lost saw the deceased alive on <b>1-27-1960</b> and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3105 N. Charles St. Baltimore, 18. Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>R. H. Silver</b>		M.D. <b>3105 N. Charles St. Baltimore, 18. Md.</b>					
PHYSICIAN'S NAME (Type) <b>R. H. Silver</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				24a. RECEIVED BY REGISTRAR <b>FEB 1 1960</b>		24b. REGISTRAR'S SIGNATURE <b>James P. ...</b>	

Brooks Memorial Service, Townson, Md.

Burial 1-30-50 Sherwood Episcopal Cooneyville, Md.

James H. Sweet  
1750  
1-27-50

William H. Sweet  
1750  
1-27-50

Miss to state (unclear)  
the same as Lt. Robert (unclear)

Russell I. Sweet, Cooneyville, Md.

Henry Hess

Elizabeth Lister

Hounsville

Maryland

Female White

8-4-1870

Anna Hess Knott

1-27-50

Walter Ford

22 E. Annapolis St.

Cooneyville

77

EX Baltimore 23

Baltimore

Maryland

CERTIFICATE OF DEATH

0843



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G254 1-20-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00325

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8118 Old Philadelphia Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>KRUL</u> Last <u>KRUL</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1885</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Setera</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Jonczak</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Teresa Kowalewski</u>		Address <u>8118 Old Phila. Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>59</u> , to <u>JAN</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 11</u> , 19 <u>60</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Orth, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8019 Philadelphia Rd.</u> <u>1.11.60</u>	
PHYSICIAN'S NAME (Type) <u>John G. Orth</u>		<u>8019 Philadelphia Road</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M.F. SADOWSKI &amp; SONS, 1808 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>JAN 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

CERTIFICATE OF DEATH

AGE 18

NAME OF DECEASED JAMES EARL RAY		SEX Male		DATE OF BIRTH May 1, 1928		PLACE OF BIRTH Jackson, Mississippi	
OCCUPATION None		MARRIAGE Single		DATE OF DEATH May 1, 1968		PLACE OF DEATH Jackson, Mississippi	
CAUSE OF DEATH Gunshot wound		MANNER OF DEATH Homicide		TIME OF DEATH 10:00 AM		PLACE OF DEATH Jackson, Mississippi	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF CORONER J. Edgar Hoover		SIGNATURE OF WITNESS J. Edgar Hoover		SIGNATURE OF WITNESS J. Edgar Hoover	
CITY OF DEATH Baltimore		COUNTY OF DEATH Baltimore		STATE OF DEATH Maryland		ZIP CODE 21201	

1

1

THIS IS A PRELIMINARY REPORT OF DEATH. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH RECORDS. IT IS TO BE MAINTAINED IN THE DEPARTMENT OF HEALTH RECORDS. IT IS TO BE MAINTAINED IN THE DEPARTMENT OF HEALTH RECORDS.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG255 1-29-60 et

Reg. Dist. No.

00326

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>About 15 yr 53 Dundalk</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>241 Ashwood Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old North Point &amp; Oakwood Roads</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert Nelson Lang Jr.</b>		4. DATE OF DEATH <b>January 21, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1911</b>
9. AGE (In years and birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. County</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Lang</b>		14. MOTHER'S MAIDEN NAME <b>Gertruda Nelson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-9833</b>	
17. INFORMANT <b>Mrs. Doris Lang</b>		Address <b>267 Colgate Ave. 22, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis Md</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-25-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		22d. LOCATION (City, town, or county) (State) <b>German Hill Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Frank</b>	

MINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00327

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Pines</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ida</i> Middle <i>Lazerow</i> Last <i>Lazerow</i>		4. DATE OF DEATH Month <i>1-</i> Day <i>11-</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>77</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
13. FATHER'S NAME <i>Soma</i>		14. MOTHER'S MAIDEN NAME <i>not known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Julius Lazerow</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ch. Coronary Sclerosis</i> DUE TO (c) <i>Ch. Hypertensive Cardiovascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12h</i> <i>27m</i> <i>15m</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 10</i> , 1958, to <i>January 11</i> , 1960, that I last saw the deceased alive on <i>January 9</i> , 1960, and that death occurred at <i>6:47</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		ADDRESS (Street, city or town, state) <i>6209 Frederick Ave. Baltimore 28, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>		DATE SIGNED <i>1/12/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>1-12-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>United Hebrew</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Mc</i> ADDRESS <i>2100 Euton Place</i>		24a. REC'D BY REGISTRAR <i>Jan 12 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Charles S. K...</i>	

CERTIFICATE OF DEATH

1932

1932

*[Faint, mostly illegible handwritten text follows, likely containing personal and medical details of the deceased.]*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G255 1/27/60 iwk  
0346  
CERTIFICATE OF DEATH

00328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>6.</i>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <i>Trusting Ave. Nursing Home</i>		e. IS RESIDENCE ON A FARM? <i>NO</i>	
3. NAME OF DECEASED (Type or print) <i>Myrtle V. Lennon</i>		4. DATE OF DEATH <i>Jan 12 1960</i>	
5. SEX <i>F.</i>	6. COLOR OF RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 28, 1886</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Strahler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Nixon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Mary O. Mendez</i>		Address <i>Balto. 7. Old County Ridge Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 da.</i> <i>10 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-11-1959</i> to <i>1-12-1960</i> , that I last saw the deceased alive on <i>1-22-1960</i> , and that death occurred at <i>10:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		ADDRESS (Street, city or town, state) <i>6209 Frederick Ave.</i>	
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>		DATE SIGNED <i>1-12-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/15/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Balto.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Byers</i>		ADDRESS <i>8728 Lifestylld. Randallstown, Md.</i>	
24a. REG'D BY REGISTRAR <i>JAN 20 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

1  
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film G255 1/27/60 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No.

00329

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>527 Acter Avenue</u>		d. STREET ADDRESS <u>3802 Reisterstown Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Malhe</u> Middle <u>Levitt</u> Last <u>Levitt</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Aiken</u>		14. MOTHER'S MAIDEN NAME <u>Conne R ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>ASCVD</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>60</u> , to <u>1/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>60</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. J. Ellin</u>		ADDRESS (Street, city or town, state) <u>8627 Liberty Rd</u> DATE SIGNED <u>1/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Morton J. Ellin</u>		<u>Randallstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pozvohler Friendly</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Lewison &amp; Bros</u> ADDRESS <u>6010 Reisterstown Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Krasa</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10083

STATE OF TEXAS

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "I hereby certify" and "in presence of" are faintly visible.]*

*[Faint vertical text on the right margin, possibly a date or page number.]*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0348

## CERTIFICATE OF DEATH

00330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>1800 Wilhelm Ave. -6</b> <b>Balto. Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Balto. Co.</b> <b>1800 Wilhelm Ave. 6</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>			c. LENGTH OF STAY IN lb <b>5yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale Md. Balto. Co.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1800 Wilhelm Ave. 6</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>William S. Leyh Sr.</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1886</b>		9. AGE (In years last birthday) yrs. <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Amer. Smelting Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>---Leyh</b>				14. MOTHER'S MAIDEN NAME <b>Lena Leohr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>212-10-1508</b>		17. INFORMANT <b>Mrs. Margaret K. Leyh.</b> Address <b>1800 Wilhelm Ave. Balto. Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction (Coronary Vascular Disease)</b> <b>443X</b> DUE TO <b>Myocardial Infarction. Rt. side</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerosis (Generalized)</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>2 days.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/15/60</b> to <b>1/27/60</b> , that I last saw the deceased alive on <b>1/27/60</b> , 19 <b>60</b> , and that death occurred at <b>6:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>W. S. Leyh Sr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>2529 Eastern Ave.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 1, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip H. H. H.</b> ADDRESS <b>2024 Orleans St. 31</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. H. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0349

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>A</b> Last <b>Lins</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>FM</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-3-1877</b>	
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>3</b>		IF UNDER 24 HRS. Hours <b>4</b> Min. <b>3</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>HENRY Zinkhan</b>				14. MOTHER'S MAIDEN NAME <b>MARY Sch River</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT Address <b>George M. Lins, Phoenix, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2° complication of pneumonia</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>2 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus and Arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>December 9, 1960</b> , to <b>January 6, 1960</b> , that I last saw the deceased alive on <b>January 5, 1960</b> , and that death occurred at <b>10:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Henry L. McCorkle</b>				ADDRESS (Street, city or town, state) <b>Jarvettville, Lake, Phoenix Md</b>			
PHYSICIAN'S NAME (Type) <b>Henry L. McCorkle MD</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-11-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>United Church Christ</b>		22d. LOCATION (City, town, or county) (State) <b>Jacksonville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

00331

RECORDS OF DEATH

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1  
X  
M  
090  
I  
0  
1  
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0350 CERTIFICATE OF DEATH

Reg. Dist. No.

00332

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>4906 Loch Raven Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELZA</u> Middle <u>W.</u> Last <u>LITTLE</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 15, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR <u>IF UNDER 24 HRS.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles White</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Bachler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. J. C. Driscoll</u>		Address <u>417 Wingate Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular renal disease</u> 442X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28, 1957</u> to <u>Jan 10, 1960</u> , that I last saw the deceased alive on <u>Jan 9, 1960</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederick J. Vollmer</u>		ADDRESS (Street, city or town, state) <u>6100 York Rd., Balto-12 Md.</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u>		DATE SIGNED <u>1/11/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/12/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickener &amp; Sons - Balto 1744</u>		24a. REC'D BY REGISTRAR <u>JAN 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>		DATE	

10000

WEST VIRGINIA DEPARTMENT OF HEALTH - HALL HONOR 10  
DEATH CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented horizontally but contains vertical text labels for fields like 'Name', 'Date', and 'Place of Birth'. The text is faint and difficult to read.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0351

## CERTIFICATE OF DEATH

00333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
c. LENGTH OF STAY IN 1b <u>30 yrs</u>				d. STREET ADDRESS <u>213 Eastern Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>213 Eastern Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Edwin Lowe</u>				4. DATE OF DEATH Month Day Year <u>Jan 3 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 26 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter Carrier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>			
13. FATHER'S NAME <u>John B. Lowe</u>				14. MOTHER'S MAIDEN NAME <u>Carrie E. Bruth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>one war</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Ellen E. Wieneke</u>				Address <u>4304 Nicholas Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Atherosclerotic Cardiovascular Disease</u> (b) <u>Diase</u> DUE TO <u>109Ks.</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>June 1957</u> 19 <u>57</u> to <u>January 3</u> 19 <u>60</u> that I last saw the deceased alive on <u>JAN 3</u> 19 <u>60</u> and that death occurred at <u>8:00 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Gessner</u> M.D.				ADDRESS (Street, city or town, state) <u>701 Eastern Avenue</u> DATE SIGNED <u>Balto 21, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JOHN E. GESSNER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Duggel Bros 7110 Belair Rd</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JAN 6 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00334

0352 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3600 Kelox Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>F.</u> Last <u>MALDEIS, SR.</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1883</u>	9. AGE (In years lost birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auto Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>
13. FATHER'S NAME <u>Rheinhold Maldeis</u>				14. MOTHER'S MAIDEN NAME <u>Amalie Melcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-4009</u>		INFORMANT Address <u>Mr. Albert Maldeis, Jr.-749 Charing Cross Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>*****</u>					
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>*****</u>		20f. (City or town) (County) (State) <u>*****</u>	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>58</u> , to <u>Jan</u> , 19 <u>60</u> that I last saw the deceased alive on <u>15 January</u> , 19 <u>60</u> and that death occurred at <u>4:00 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Millard T. Traband, Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>5101 Gwynn Oak Avenue, Baltimore, 7, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tischer</u>				ADDRESS <u>Balto - 17, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 20 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>			

MEDICAL CERTIFICATION

00304

CERTIFICATE OF DEATH

00304

*Handwritten signature*

*Handwritten signature*

1900

1900

1900

11

CC

1900

1900

1900

1900

1900

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00355

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Mt. Wilson</u>		<u>19 days</u>		TOWN <u>BALTIMORE CITY</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Mt. Wilson State Hospital</u>				<u>167 NORTH MONASTERY AVE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>JOSEPH PATRICK MANNION</u>				<u>JANUARY 26 1960</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>MALE</u>		<u>WHITE</u>		<u>MARRIED</u>		<u>APRIL 5, 1900</u>	
10e. USUAL OCCUPATION (Give kind of work done during, most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday		IF UNDER 1 YEAR	
<u>FIRE FIGHTER</u>		<u>CITY FIRE DEPT.</u>		<u>59</u> yrs.		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
<u>BALTIMORE MARYLAND</u>				<u>USA</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN JOSEPH MANNION</u>				<u>BRIDGETT A. MCNAHAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>YES</u>		<u>218-36-8174</u>		<u>Hospital Records</u>			
				<u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>2 YEARS</u>	
IMMEDIATE CAUSE (A) <u>PULMONARY TUBERCULOSIS</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/7</u> , 19 <u>60</u> , to <u>1/26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>60</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
<u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Maryland</u>		<u>12611.0</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/29/60</u>		<u>New Cathedral Cem.</u>		<u>Baltimore</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Charles L. Stevens</u>		<u>Charles L. Stevens</u>		<u>Charles L. Stevens Funeral Home Inc.</u>		<u>1501 E. Fort Ave.</u>	
DATE <u>29 '60</u>							



# CERTIFICATE OF DEATH

Reg. No. 10

1. NAME OF DECEASED

MARYLAND

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

USUAL RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

USUAL RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

USUAL RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

USUAL RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

USUAL RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

USUAL RESIDENCE

REGISTERED

1. NAME OF DECEASED

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. EDUCATION

8. RELIGION

9. USUAL RESIDENCE

10. DATE OF BIRTH

11. PLACE OF BIRTH

12. EDUCATION

13. RELIGION

14. USUAL RESIDENCE

15. DATE OF BIRTH

16. PLACE OF BIRTH

17. EDUCATION

18. RELIGION

19. USUAL RESIDENCE

20. DATE OF BIRTH

21. PLACE OF BIRTH

22. EDUCATION

23. RELIGION

24. USUAL RESIDENCE

25. DATE OF BIRTH

26. PLACE OF BIRTH

27. EDUCATION

28. RELIGION

29. USUAL RESIDENCE

30. DATE OF BIRTH

31. PLACE OF BIRTH

32. EDUCATION

33. RELIGION

34. USUAL RESIDENCE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>X</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1612 Ingleside Avenue</b>		d. STREET ADDRESS <b>1612 Ingleside Avenue #7</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ADELE</b> Middle <b>LUCKETT</b> Last <b>MANTLER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1900</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.	IF UNDER 24 HRS. Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Punch Press Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Electric Co. Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Eugene Ba-Tham</b>		14. MOTHER'S MAIDEN NAME <b>Mary Luckett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-20-5816</b>	
INFORMANT <b>Miss Helen A. Mantler-1612 Ingleside Avenue</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RT Sided C.V.A.</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis generalized</b> DUE TO (c) <b>Intoxication</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 29, 1958</b> to <b>1/25, 1960</b> , that I last saw the deceased alive on <b>1/25, 1960</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4605 EDMONDSON AVE BALTO MD</b> DATE SIGNED <b>1/26/60</b>			
ACTUAL SIGNATURE <b>Cliff Ratliff Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF JR. BALTO 29, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/28/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker</b> ADDRESS <b>BALTO - 17, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 27 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>

U3301

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

03-2



Form with multiple sections for medical and administrative data, including fields for patient name, date of birth, sex, race, and cause of death. The form is divided into several horizontal sections by lines, with some sections containing sub-headers. The text is mostly illegible due to the quality of the scan.

## 0355 CERTIFICATE OF DEATH

Reg. Dist. No.

00357

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>51</b> <b>Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b>		d. STREET ADDRESS <b>5701 - 1st Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>EDWARD</b> Last <b>MARKS</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>15,</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1870</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired (Signal Maintenance) Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Ruth Leatherwood - Box 232-Forest Rd.</b>		Address <b>Hanover, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>pulling down</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiac failure</b> (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs</b> <b>5 hrs</b> <b>arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Age</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1957</b> to <b>Jan 15, 1960</b> , that I last saw the deceased alive on <b>Jan 15, 1960</b> , and that death occurred at <b>1:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Cliff Ratliff Jr</b> M.D.		ADDRESS (Street, city or town, state) <b>4605 Edmondson</b> DATE SIGNED <b>1/16/60</b>	
PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFE JR</b>		<b>Balto 29, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Pickner &amp; Sons - Balt</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	
ADDRESS <b>Balto</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TABLE 1. *Continued*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0356 CERTIFICATE OF DEATH

00338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13 Kingsley Road</b>		d. STREET ADDRESS <b>13 Kingsley</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>Mason</b> Last <b>Marquess</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1926</b>
9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Mason E. Marquess</b>		14. MOTHER'S MAIDEN NAME <b>Ida May Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mason E. Marquess</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Multiple birth defects especially malaformation of chest</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>January 15, 1955</b> , to <b>January 15, 1960</b> , that I last saw the deceased alive on <b>January 15, 1960</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin E. Strobel</b>		ADDRESS (Street, city or town, state) <b>48 Main Street</b>	
PHYSICIAN'S NAME (Type) <b>Martin E. Strobel M.D.</b>		DATE SIGNED <b>1-18-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 18/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>All Saints</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>	
ADDRESS <b>Reisterstown, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

DATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

COUNTY OF BALTIMORE

DEATH OF

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
00359  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
035  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>203 N. Rolling Rd</i>		d. STREET ADDRESS <i>203 N. Rolling Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Thomas E. Massey</i>		4. DATE OF DEATH <i>Jan. 28 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) <i>80</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired B. &amp; O. R. R.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ind.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Massey</i>		14. MOTHER'S MAIDEN NAME <i>Doner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Thomas E. Massey</i>	
17. INFORMANT <i>Thomas E. Massey</i>		Address <i>1303 Frederick Rd Catonsville 28 Ind.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis.</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Extensive.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>INTERVAL BETWEEN ONSET AND DEATH</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 1959</i> to <i>1/28/60</i> that (I) <i>last</i> saw the deceased alive on <i>1/28/60</i> , and that death occurred at <i>10:30 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>W. E. Mc Grath</i>		22b. DATE SIGNED <i>1/29/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. E. Mc Grath</i>		22d. ADDRESS <i>1303 Frederick Rd Catonsville 28 Ind.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/1/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. View</i>		23d. LOCATION (City, town, or county) (State) <i>Howard Co. Ind.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Mc Grath &amp; Son</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	
24a. ADDRESS <i>28</i>		25a. REC'D BY REGISTRAR <i>FEB 1 '60</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
X  
I  
O  
1

1  
M  
X  
I  
O  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0358 CERTIFICATE OF DEATH

00340

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb <b>5yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1923 Old Frederick Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>H. Matthews</b> Last 4. DATE OF DEATH Month <b>Jan.</b> Day <b>23</b> Year <b>1960</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 23, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tank Tester</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Boiler Ind.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>Joseph Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Etta Drener</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Anna M. Matthews</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONITIS, BILATERAL</b> DUE TO <b>490 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 1953</b> to <b>JAN 1/23 1960</b> , that (I) (we) lost saw the deceased alive on <b>1/23</b> 19 <b>60</b> , and that death occurred at <b>6:55</b> PM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Herbert W. Lapp</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>Jan 25, '60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert W. Lapp M. D.</b>				22d. ADDRESS <b>4804 Frederick Rd. Balto. 29, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond Jones</b>				ADDRESS <b>4001 Ritchie Hgwy.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 29 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

03340

03340  
CENTRAL CHURCH OF DEATH

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

03340

31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

31

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00341

0221 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1932 Cedar Lane</b>		d. STREET ADDRESS <b>1932 Cedar Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANK</b> First <b>X.</b> Middle <b>MAURER</b> Last		4. DATE OF DEATH <b>January 6,</b> 19 <b>60</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 4, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian Maurer</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Pfeiffer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Helen T. Maurer 6 Playfield</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Emphysema</b> DUE TO (c) <b>Duodenal ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> 19 <b>55</b> , to <b>1/6</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> 19 <b>60</b> , and that death occurred at <b>3:30</b> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Eugene F. Navy</b>		22b. DATE SIGNED <b>1/8/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Eugene F. Navy</b>		22d. ADDRESS <b>7001 MORNINGTON ROAD BALTO 23, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/9/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION (City, town, or county) (State) <b>Dundalk, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 12 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

0321 CERTIFICATE OF DEATH



*[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through. Some words like 'DEATH', 'CERTIFICATE', and '0321' are visible.]*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0359

## CERTIFICATE OF DEATH

Reg. Dist. No.

00342

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>808 Southridge Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>—</u> Last <u>MAZZEO</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	11. IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAKING</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAZZEO</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MARIE MAZZEO</u>		Address <u>808 Southridge Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350X Cerebral Hemorrhage</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Parkinsons Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>9-19-1955</u> to <u>1-3-60</u> , that I last saw the deceased alive on <u>1-2-60</u> , 19 <u>—</u> , and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry S. Gimbel</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 Snowden Ave</u> DATE SIGNED <u>1-6-60</u>	
PHYSICIAN'S NAME (Type) <u>HARRY S. GIMBEL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEO. L. SCHWAB FUNERAL HOME</u> <u>Francis H. Miller 2101 Frederick Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 11 1961

0330

CHURCH OF GOD

0330

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00343

1. NAME OF DECEASED (Type or Print) <i>Mary Rose McCarthy</i>		2. DATE OF DEATH <i>January 26, 1960</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Baltimore County</i> FULL NAME OF HOSPITAL OR INSTITUTION <i>Armocost Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>3V01-4</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3803 Elerslie Ave.</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i>	8. DATE OF BIRTH <i>August 11, 1887</i>
9. AGE (In years last birthday) <i>72</i>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housekeeper</i>	10. B. KIND OF BUSINESS OR INDUSTRY <i>Church Rectory</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Dennis McCarthy</i>		14. MOTHER'S MAIDEN NAME <i>Ann Sweeney</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-05-9112</i>	
17. INFORMANT <i>Michael J. McCarthy</i>		ADDRESS <i>3803 Elerslie Ave.</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>154x I Carcinoma of rectum</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Carcinoma of rectum</i> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 mos.</i> <i>?</i> <i>?</i>	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION <i>Oct 1958</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of rectum</i>
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 24, 1958</i> to <i>Jan 26, 1960</i> that (I) (we) last saw the deceased alive on <i>Jan 25, 1960</i> and that in (my) (our) opinion death occurred at <i>11:15 A.M.</i> from the causes and on the date stated above.			
23A. SIGNATURE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>Fredrick J. Hollander</i>		23B. ADDRESS <i>6100 York Rd - 12</i>	
23C. DATE SIGNED <i>Jan. 27, 1960</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Jan 29, 1960</i>	24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 '60</i>		25B. NAME OF REGISTRAR <i>Christine S. Thomas</i>	
		25C. FUNERAL DIRECTOR <i>John A. Moran</i>	
		ADDRESS <i>3000 E. Baltimore St.</i>	

THIS IS A PERMANENT RECORD. ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. SE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

ICAL CERTIFICATION

[illegible]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00344

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>0361</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>513 Fairmount Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b> d. STREET ADDRESS <b>513 Fairmount Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ESTER</b> Middle <b>White</b> Last <b>McNeave</b>		4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frances Snyder, daughter</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spontaneous intracerebral hemorrhage with rupture into ventricular system</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/27/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 28, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>FEB 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>	

[illegible]

Jan. 28, 1900. Baltimore National Cemetery, Baltimore, Maryland.

01100000

On June 10, 1997, the

Ohio

11-10-1963

1991, 1992, 1993

est: 2000

002407

00000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00345

0362

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7826b Eastern Ave.</b>		d. STREET ADDRESS <b>7826 Eastern Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SOPHIA C. MOFFET</b>		4. DATE OF DEATH Month Day Year <b>January 3, 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>April 7, 1874</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Knorr</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Leech</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mrs. Mary Kemp 7826 Eastern Ave-24</b>	
17. INFORMANT <b>Mrs. Mary Kemp 7826 Eastern Ave-24</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>6 months</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1950</b> to <b>Jan 3, 1960</b> , that I last saw the deceased alive on <b>Jan 2, 1960</b> , and that death occurred at <b>10:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1010 NORTH Point Rd</b> DATE SIGNED <b>1/4/60</b> ACTUAL SIGNATURE <b>Morris A. Jacobs</b> M.D. PHYSICIAN'S NAME (Type) <b>Morris A. Jacobs</b> <b>Baltimore, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0222 CERTIFICATE OF DEATH

00346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>				c. LENGTH OF STAY IN 1b <b>25 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Arrowship Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>++++</b> Last <b>MORGAN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25th</b> Year <b>19 60</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1867</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Swansea, South Wales</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Walters</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Morgan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Margaret Thomas</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 15, 1953</b> , to <b>JAN 25, 1960</b> , that I last saw the deceased alive on <b>JAN 25, 1960</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David H. Andrew</b>		M.D. <b>33 Dundalk Avenue</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>1/26/60</b>	
PHYSICIAN'S NAME (Type) <b>David H. Andrew, M.D.</b>		<b>Baltimore 22, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharon, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley</b>				ADDRESS <b>Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 28 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

DEATH CERTIFICATE

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1900"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05-10-1925"]		PLACE OF MARRIAGE [Faint text, possibly "St. Mary's Church"]		NAME OF SPOUSE [Faint text, possibly "Jane Doe"]	
DECEASED AT [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "11-01-1945"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF INTERMENT [Faint text, possibly "St. Mary's Cemetery"]		DATE OF INTERMENT [Faint text, possibly "11-05-1945"]		NAME OF CLERGYMAN [Faint text, possibly "Rev. J. H. Smith"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]		SIGNATURE OF CLERGYMAN [Faint text, possibly "Rev. J. H. Smith"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the family or friends of the deceased, or by the coroner or other official having charge of the body, and by the clergyman who has performed the funeral services. It is to be filled out in full, and the information given is to be true and correct. It is to be signed by the person who has filled it out, and by the physician or other person who has attended the deceased, or by the family or friends of the deceased, or by the coroner or other official having charge of the body, and by the clergyman who has performed the funeral services. It is to be filed with the Registrar of the Department of Health, and a copy is to be sent to the family of the deceased.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00347

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Rosewood State Training School</u> <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> <u>1556-2</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills M.D. by same name.</u>		c. LENGTH OF STAY IN 1b <u>10 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>4307 GARRETT PARK RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>PATRICIA</u> Middle <u>EILEEN</u> Last <u>MOSHER</u>		4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-50</u>
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u>23</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (State or foreign country) <u>Istanbul, Turkey</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Bernard</u> <u>XXXXXXXXXXXX</u> <u>Mosher</u>	
14. MOTHER'S MAIDEN NAME <u>MAUREEN BERNADETTE FRAWLEY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Bernard Mosher-father-same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonitis</u> <u>500x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Bronchitis</u> DUE TO (c) <u>Symptomatic Epilepsy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Two weeks</u> <u>Two weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Symptomatic Epilepsy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 23</u> , 19 <u>60</u> , to <u>Jan 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>24 Jan</u> , 19 <u>60</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry G. Boteler</u> M.D.		ADDRESS (Street, city or town, state) <u>Owings Mills, Md</u> DATE SIGNED <u>24 Jan 60</u>	
PHYSICIAN'S NAME (Type) <u>Harry G. Boteler</u>		<u>Owings Mill, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	24a. REC'D BY REGISTRAR <u>JAN 26 '60</u>
24b. REGISTRAR'S SIGNATURE <u>Robert S. Hanes</u>			

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Signature of physician: [illegible]

6. Signature of registrar: [illegible]



0364

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> 13x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>292 W. Main Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN L. MURK</u>		4. DATE OF DEATH Month Day Year <u>January 5 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1919</u>
9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Catonsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Murk</u>		14. MOTHER'S MAIDEN NAME <u>Anna Affeldt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>213-10-7333</u>	
INFORMANT Address		<u>Clin. Rec., VAH, Balto. 18, Md. Fort Howard Division</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>LAENNEC'S CIRRHOSIS</u> DUE TO (c) <u>EDEMA OF LUNGS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>FEW HOURS</u> <u>2 YEARS</u> <u>FEW HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3:00 AM 1/5, 1960</u> to <u>2:05 PM 1/5, 1960</u> , that I last saw the deceased alive on <u>1/5, 1960</u> and that death occurred at <u>2:05 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Crawford</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>VAH, BALTO. 18, MD. FORT HOWARD DIV. 1/6/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN W. CRAWFORD, M.D.</u>		<u>VAH, Baltimore 18, Md. Ft. Howard Div 1/6/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u>	
<u>F.C. Higinbotham, 106 Columbia R., Ellicott Cy. Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22:

• • •

10

• *Journal of the American Medical Association*, 2000; 284: 2639-2644

50-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0365

## CERTIFICATE OF DEATH

00349

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Granite</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Acme Ave.</b>		e. STREET ADDRESS <b>Acme Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>JACOB</b> First <b>THOMAS</b> Middle <b>NASH</b> Last		4. DATE OF DEATH Month <b>Jan.</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-13-1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stone cutter</b>	
11. BIRTHPLACE (State or foreign country) <b>Woodstock, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph H Nash</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Jane Albright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. F.L. Brantley, Granite, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>Jan 1/23, 1960</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Tom E. Martin</b>		ADDRESS (Street, city or town, state) <b>Presidents town Md</b>	
PHYSICIAN'S NAME (Type) <b>Wm. E. Martin</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-26-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Granite Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 27 '60</b>	
ADDRESS <b>Ellicott City, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00350

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>509 Reisterstown Road</u>				d. STREET ADDRESS <u>509 Reisterstown Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles E.</u> Middle <u>Naylor</u> Last <u>Naylor</u>				4. DATE OF DEATH Jan. <u>6</u> 19 <u>60</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1, 1872</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Plaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plastering</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr Robert E. Miller</u> Address <u>509 Reisterstown Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured Rt. Hip.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home &amp; broke hip.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Feb 22</u> 19 <u>59</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pikesville Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>				ADDRESS <u>8728 Liberty Rd.</u> <u>Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

DATE SIGNED

1-8-60



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's findings.

1. PATIENT INFORMATION

2. MEDICAL HISTORY

3. PHYSICAL EXAMINATION

4. LABORATORY EXAMINATIONS

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SIGNATURES



## 0367 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1mth22dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rollie</u> Middle <u>Neifert</u> Last <u>Neifert</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1894</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown Hoisting Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown Henry Neifert</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Elizabeth Clatterbuck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>C20 84 27 48</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple metastases due to bronchogenic carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>of the left lung</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 16</u> , 19 <u>59</u> , to <u>Jan. 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 20</u> , 19 <u>60</u> , and that death occurred at <u>6:45a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachler</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL 1-20-60</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>		DATE SIGNED <u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Jan. 25, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chambers &amp; Son</u>		24a. REC'D BY REGISTRAR <u>1400 Chapin S.W. Washington, D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>JAN 27 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

036



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0368

## CERTIFICATE OF DEATH

Reg. Dist. No.

00352

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN 1b <u>1 yr, 10 mos.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12, Maryland</u> d. STREET ADDRESS <u>5219 Spring Lake Way</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Minnie</u> Middle _____ Last <u>Niemyer</u>		<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>25</u> Year <u>19 60</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2/10/89</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Wm. Henry Niemyer - deceased</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Catherine Mamberger - deceased</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____	
<b>16. SOCIAL SECURITY NO.</b> _____		<b>INFORMANT</b> <u>Rosewood Records</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Acute respiratory disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>  <u>2 yrs.</u>  <u>12 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify</b> that I attended the deceased from <u>March 5, 1958</u> , to <u>January 25, 1960</u> , that I lost s/he the deceased alive on <u>January 25, 1960</u> , and that death occurred at <u>12 noon</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edward J. Mathews</u> M.D. <u>Rosewood State Training School</u> PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u> <u>Owings Mills, Maryland</u>			
<b>22a. BURIAL OR CREMATION</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>Jan 28 60</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTO MD.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>PA Heumann</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE JAN 28 '60</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

1930

NEW YORK STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

NEW YORK STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

## 0309 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>21 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>---</b> Last <b>NISER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 10, 1892</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Distillery</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Philip Niser</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I 213-05-9476</b>		INFORMANT Address <b>Clin. Records, VAH, Balto. 18, Md. Ft. Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, LEFT KIDNEY</b> <b>180X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>THROMBOSIS OF LEFT RENAL ARTERY</b> <b>UREMIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>10 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 29, 1959</b> , to <b>January 19, 1960</b> , and that death occurred at <b>2:38 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. J. Pijanowski</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION 1/19/60</b>			
PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 19 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Toulson</b>				ADDRESS <b>2359 Washington Blvd. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Peltz</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

(34)

Date

1. Name of Deceased

2. Age

3. Sex

4. Race

5. Occupation

6. Cause of Death

7. Place of Death

8. Date of Death

9. Name of Physician

10. Name of Registrar

11. Name of Coroner

12. Name of Undertaker

13. Name of Burial Place

14. Name of City



## 0370 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St Joseph's Nursing Home</i>				d. STREET ADDRESS <i>604 Craycombe Ave.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Frank</i> Middle <i>J.</i> Last <i>Oberle</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>10</i> Year <i>19 60</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 14, 1882</i>	
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>jeweler</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Seraphin Oberle</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Kiedet</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Faaker G. Oberle</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro vascular thrombosis (multiple)</i> 3 mos 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C-V Disease</i> 10+ yrs DUE TO (c) <i>Arteriosclerotic Fibillation</i> 3+ yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Failure</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Dec</i> , 1959, to <i>Jan 10</i> , 1960, that I last saw the deceased alive on <i>Jan 10</i> , 1960, and that death occurred at <i>9:21</i> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Victor F. King</i>				ADDRESS (Street, city or town, state) <i>1102 E. Joppa Rd.</i>			
DATE SIGNED <i>1/11/60</i>							
PHYSICIAN'S NAME (Type) <i>Victor F. King</i>				1102 E. Joppa Rd.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1-14-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Rd</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 13 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kenna</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1739 Wycliffe Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Mary O'haughlin</u>		4. DATE OF DEATH <u>JAN. 1 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1889</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Federal Supplies</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Supplies</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Aldridge</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Barnes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-4003</u>	
17. INFORMANT <u>Mr. Everett O'haughlin</u> Address <u>Wycliffe AS</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Sq. cell carcinoma of uterine cervix</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>see "C", part I</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u> <u>17 mos.</u> <u>11 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>59</u> , to <u>January 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>January 1</u> , 19 <u>60</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Roy W. Cheenut, Jr.</u> M.D. <u>25 W. Pennsylvania Ave.</u> PHYSICIAN'S NAME (Type) <u>Roy W. Cheenut, Jr.</u> <u>Towson 4, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-4-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church of God</u>		22d. LOCATION (City, town, or county) (State) <u>Winfield, Carroll. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waltz</u> ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hance</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>10-15-1910</i></p>		<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>6. OCCUPATION <i>Teacher</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>12-1-1935</i></p>		<p>9. PLACE OF MARRIAGE <i>Baltimore, Md.</i></p>		<p>10. NAME OF SPOUSE <i>Jane Doe</i></p>	
<p>11. DATE OF DEATH <i>11-1-1955</i></p>		<p>12. TIME OF DEATH <i>10:30 AM</i></p>		<p>13. PLACE OF DEATH <i>Home</i></p>		<p>14. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>15. MANNER OF DEATH <i>Natural</i></p>	
<p>16. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>		<p>17. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>18. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>19. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESS <i>John Doe</i></p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE RETURNED TO THE PHYSICIAN WHO ISSUED IT, OR TO THE REGISTRAR, IF NOT SO RETURNED, IT WILL BE DESTROYED. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

0372

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>L.</b> Last <b>Ostrom</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1888</b>
9. AGE (In years last birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Catonsville, Md.</b> <b>Oscar B. Ostrom, 207 Glenmore Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X</b> DUE TO <b>Multiple Little Strokes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition; Decubitus ulcer; Dehydration</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>7953</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>1/9/60</b>	
21. I certify that I attended the deceased from <b>4/9/60</b> , 19 <b>19</b> , to <b>1/9/60</b> , 19 <b>19</b> , that I last saw the deceased alive on <b>4/9/60</b> , 19 <b>19</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28 Md</b>	
ACTUAL SIGNATURE <b>W. E. McGreth</b> M.D.		DATE SIGNED <b>1/11/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 12/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 7, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b> ADDRESS <b>4101 Diamond St A</b>		24a. REC'D BY REGISTRAR <b>JAN 13 1960</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>W. E. McGreth</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

0373

DECEASED  
NAME  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
SIGNATURE OF REGISTRAR  
OFFICE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0373

## CERTIFICATE OF DEATH

Reg. Dist. No.

00357

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2yr8mth12dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn, Maryland</u> <u>0250-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>5315 Fourth Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mattie</u> Middle <u>Elizabeth</u> Last <u>Oursler</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>weaver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>wo den mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Samuel Orem</u>			14. MOTHER'S MAIDEN NAME <u>Alice</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Dec. 29</u> , 19 <u>59</u> , to <u>Jan. 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 19</u> , 19 <u>60</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>1-19-60</u> ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Oakland Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll County</u> <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u> ADDRESS <u>130 E. Fort Ave #30</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>		

CERTIFICATE OF DEATH

1933

1085

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1888		Boston, Mass.	
Cause of Death		Disease		Duration		Time of Day		Place of Death	
Heart Disease		Myocardial Infarction		24 hours		10:30 AM		Home	
Physician		Hospital		Municipality		County		State	
Dr. J. Smith		St. Mary's		Boston		Suffolk		Mass.	
Signature of Registrar		Signature of Physician		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1085

## 0374 CERTIFICATE OF DEATH

00358

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			b. COUNTY <b>3V01-4</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>8 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						d. STREET ADDRESS <b>4112 <del>REX</del> Reisterstown Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>ADOLPH</b>			First <b>C.</b>			Middle <b>PARKENT</b>			Last <b>January</b>			4. DATE OF DEATH Month <b>6</b> Day <b>19</b> Year <b>60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/14/97</b>		9. AGE (In years lost birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Parkent</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Fisher</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I 214-34-4842</b>		INFORMANT <b>Clin. Records. Vet. Adm. Hosp. Balto. Md. Ft. Howard Div</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BLADDER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>CARCINOMA OF RENAL PELVIS, LEFT</b> DUE TO (c) <b>Operations: Ureteronephrectomy, 1955. Cutaneous ureterostomy 2/2/59. Total cystectomy 2/27/59. Excision bulbous portion urethra &amp; penis, and hemorrhoidectomy</b>												INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 YRS.</b> <b>5 1/2 YRS.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20c.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>December 29, 19 59</b> to <b>January 6, 19 60</b> and that death occurred at <b>12:50 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John W. Crawford</b> M.D. <b>VAH, BALTIMORE, MD. FT HOWARD DIV</b> <b>1/7/60</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b> <b>1/7/60</b>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Vernon Lemmon</b> <b>Lemmon Funeral Home 1611 Park Heights Ave. Balto. Md.</b>						24a. REC'D BY REGISTRAR DATE <b>JAN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0314 CERTIFICATE OF DEATH

NAME: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

[illegible text block containing additional details and signatures]

0375

## CERTIFICATE OF DEATH

Reg. Dist. No.

00359

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>16 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>A.</b> Last <b>PECK</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>17</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-14</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRICKLAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>IRA J. PECK</b>		14. MOTHER'S MAIDEN NAME <b>OLIVE RELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW-11 213-10-5742</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ACUTE CORONARY OCCLUSION</b> (c) <b>MARKED GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>2 DAYS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1, 19 60</b> to <b>January 17, 19 60</b> and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH BALTO MD FT HOWARD DIVISION 1-18-60</b>			
ACTUAL SIGNATURE <i>W. J. Pijanowski</i>		M.D. <b>VAH BALTO MD FT HOWARD DIVISION 1-18-60</b>	
PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>		<b>VAH BALTO MD FT HOWARD DIVISION 1-18-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-20-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM COOK-BLIGHT INC 6009 Harford Rd Balto Md</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

2524

100

2054 J. L. Shaw



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0378

## CERTIFICATE OF DEATH

Reg. Dist. No. **00360**

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Baltimore</i> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> <span style="float: right;">b. COUNTY <i>Baltimore</i> ✓</span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>3001-4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Towson Conv. Home</i>		d. STREET ADDRESS <i>2919 Christopher Ave.</i>	
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Frank</i> Middle <i>George</i> Last <i>Petrik</i>		<b>4. DATE OF DEATH</b> Month <i>Jan.</i> Day <i>27</i> Year <i>19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-28-1883</i>
9. AGE (In years lost birthday) <i>76</i> yrs.		IF UNDER 1 YEAR: Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min. <i>76</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Navy</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Petrik</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Kubec</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <i>Mrs. J. Kuehnle RFD 3 Annapolis, Md.</i>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> 782.4 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 20</i> , 19 <i>60</i> , to <i>Jan 27</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan. 27</i> , 19 <i>60</i> , and that death occurred at <i>11:45 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Laurence C. Post</i> M.D. <i>6805 York Rd</i> DATE SIGNED <i>1/27/60</i> PHYSICIAN'S NAME (Type) <i>LAURENCE C. Post</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1-30-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 1 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hanna</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0221 CERTIFICATE OF DEATH

Reg. Dist. No.

00361

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1909 Halethorpe Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>H.</b> Last <b>Pinkerton</b>		4. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/1894</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William K. Pinkerton</b>		14. MOTHER'S MAIDEN NAME <b>Louise Ehlers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Ave.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident sec. 420.1</b> DUE TO (b) <b>&amp; Hypertensive A.S.C.V.D.</b> DUE TO (c) <b>Old Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/3</b> , 19 <b>60</b> , to <b>1/16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/16</b> , 19 <b>60</b> , and that death occurred at <b>7:38</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John C. Healey</b> M.D.		ADDRESS (Street, city or town, state) <b>Halethorpe, Md</b> DATE SIGNED <b>1/18/60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. John Healey</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/19/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 29</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Baltimore, Md.,

Wife of

1909 Baltimore Ave.

John H. Pinkerton

white

1909

William H. Pinkerton

No. 1909 Baltimore Ave. Baltimore, Md.

Dr. John Healy

1909

Howard H. Healy

## 0377 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE, MD.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1416 FRANCKE AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HORACE</b> Middle <b>H.</b> Last <b>PLATT</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 5, 1909</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b> Hours <b>50</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INDUSTRIAL ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNSYLVANIA</b>	
11. BIRTH PLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HORACE H. PLATT</b>		14. MOTHER'S MAIDEN NAME <b>ISABEL JOHNSTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>1163-019928</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>163X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-10-60</b> to <b>1-10-60</b> , that I last saw the deceased alive on <b>1-10-60</b> , and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William C. Helfrich</b> M.D.		ADDRESS (Street, city or town, state) <b>5006 Roland Ave</b> DATE SIGNED <b>1-12-60</b>	
PHYSICIAN'S NAME (Type) <b>Balto 10, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>JAN 14, 1960</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>WEST LAUREL HILLS</b>	22d. LOCATION (City, town, or county) (State) <b>PHILADELPHIA, PENNSYLVANIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY W. JENKINS SONS CO</b> ADDRESS <b>4905 YORK RD. BALT 12, MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 12 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME: HENRY WILSON  
AGE: 72 YRS  
DATE OF BIRTH: JAN 10 1880  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: FEB 2 1952  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
SIGNATURE: [illegible]  
TESTAMENTS: [illegible]

TESTAMENTS: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]  
PLACE: [illegible]  
CAUSE: [illegible]  
TESTAMENTS: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]  
PLACE: [illegible]  
CAUSE: [illegible]



0378 CERTIFICATE OF DEATH

Reg. Dist. No.

00363

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8301 Old Harford Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>M.</b> Last <b>POGNETTKI</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1886</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Zazech</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Dorothy Golliday 8301 Old Harford Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY HEMORRAGE</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>METASTATIC CARCINOMA OF LUNG</b> (c) <b>PRIMARY CARCINOMA OF STOMACH</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONGESTIVE HEART FAILURE</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1:25</b> , 19 <b>60</b> , to <b>1:29</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1:29</b> , 19 <b>60</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John G. Orth, M.D.</b>				ADDRESS (Street, city or town, state) <b>8619 Philadelphia Rd</b> DATE SIGNED <b>1-29-60</b>			
PHYSICIAN'S NAME (Type) <b>John G. Orth, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		22d. LOCATION (City, town, or county) (State) <b>German Hill Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John J. Duda 7922 Wise Ave. 22, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Huns</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

•

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0379

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

00364

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>113 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carroll Younger Pomeroy</b>				4. DATE OF DEATH Month Day Year <b>Jan 22 1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1899</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James H. Pomeroy</b>				14. MOTHER'S MAIDEN NAME <b>Mary O'Connor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-24-8939</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aplastic Anemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 2</b> , 19 <b>59</b> , to <b>Jan 22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 22</b> , 19 <b>60</b> , and that death occurred at <b>7:15 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b>				PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/26/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Louis Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Chesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A Donovan - 3818 Plankline</b>				24a. REC'D BY REGISTRAR <b>Jan 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1900</u></p>	
<p>5. Place of birth: <u>Johns Hopkins</u></p>		<p>6. Date of death: <u>Jan 20, 1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Johns Hopkins</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Jan 20, 1945</u></p>		<p>12. Place of registration: <u>Johns Hopkins</u></p>	
<p>13. Signature of registrar: <u>John Doe</u></p>		<p>14. Signature of registrar: <u>John Doe</u></p>	
<p>15. Signature of registrar: <u>John Doe</u></p>		<p>16. Signature of registrar: <u>John Doe</u></p>	
<p>17. Signature of registrar: <u>John Doe</u></p>		<p>18. Signature of registrar: <u>John Doe</u></p>	
<p>19. Signature of registrar: <u>John Doe</u></p>		<p>20. Signature of registrar: <u>John Doe</u></p>	
<p>21. Signature of registrar: <u>John Doe</u></p>		<p>22. Signature of registrar: <u>John Doe</u></p>	
<p>23. Signature of registrar: <u>John Doe</u></p>		<p>24. Signature of registrar: <u>John Doe</u></p>	
<p>25. Signature of registrar: <u>John Doe</u></p>		<p>26. Signature of registrar: <u>John Doe</u></p>	
<p>27. Signature of registrar: <u>John Doe</u></p>		<p>28. Signature of registrar: <u>John Doe</u></p>	
<p>29. Signature of registrar: <u>John Doe</u></p>		<p>30. Signature of registrar: <u>John Doe</u></p>	
<p>31. Signature of registrar: <u>John Doe</u></p>		<p>32. Signature of registrar: <u>John Doe</u></p>	
<p>33. Signature of registrar: <u>John Doe</u></p>		<p>34. Signature of registrar: <u>John Doe</u></p>	
<p>35. Signature of registrar: <u>John Doe</u></p>		<p>36. Signature of registrar: <u>John Doe</u></p>	
<p>37. Signature of registrar: <u>John Doe</u></p>		<p>38. Signature of registrar: <u>John Doe</u></p>	
<p>39. Signature of registrar: <u>John Doe</u></p>		<p>40. Signature of registrar: <u>John Doe</u></p>	
<p>41. Signature of registrar: <u>John Doe</u></p>		<p>42. Signature of registrar: <u>John Doe</u></p>	
<p>43. Signature of registrar: <u>John Doe</u></p>		<p>44. Signature of registrar: <u>John Doe</u></p>	
<p>45. Signature of registrar: <u>John Doe</u></p>		<p>46. Signature of registrar: <u>John Doe</u></p>	
<p>47. Signature of registrar: <u>John Doe</u></p>		<p>48. Signature of registrar: <u>John Doe</u></p>	
<p>49. Signature of registrar: <u>John Doe</u></p>		<p>50. Signature of registrar: <u>John Doe</u></p>	
<p>51. Signature of registrar: <u>John Doe</u></p>		<p>52. Signature of registrar: <u>John Doe</u></p>	
<p>53. Signature of registrar: <u>John Doe</u></p>		<p>54. Signature of registrar: <u>John Doe</u></p>	
<p>55. Signature of registrar: <u>John Doe</u></p>		<p>56. Signature of registrar: <u>John Doe</u></p>	
<p>57. Signature of registrar: <u>John Doe</u></p>		<p>58. Signature of registrar: <u>John Doe</u></p>	
<p>59. Signature of registrar: <u>John Doe</u></p>		<p>60. Signature of registrar: <u>John Doe</u></p>	
<p>61. Signature of registrar: <u>John Doe</u></p>		<p>62. Signature of registrar: <u>John Doe</u></p>	
<p>63. Signature of registrar: <u>John Doe</u></p>		<p>64. Signature of registrar: <u>John Doe</u></p>	
<p>65. Signature of registrar: <u>John Doe</u></p>		<p>66. Signature of registrar: <u>John Doe</u></p>	
<p>67. Signature of registrar: <u>John Doe</u></p>		<p>68. Signature of registrar: <u>John Doe</u></p>	
<p>69. Signature of registrar: <u>John Doe</u></p>		<p>70. Signature of registrar: <u>John Doe</u></p>	
<p>71. Signature of registrar: <u>John Doe</u></p>		<p>72. Signature of registrar: <u>John Doe</u></p>	
<p>73. Signature of registrar: <u>John Doe</u></p>		<p>74. Signature of registrar: <u>John Doe</u></p>	
<p>75. Signature of registrar: <u>John Doe</u></p>		<p>76. Signature of registrar: <u>John Doe</u></p>	
<p>77. Signature of registrar: <u>John Doe</u></p>		<p>78. Signature of registrar: <u>John Doe</u></p>	
<p>79. Signature of registrar: <u>John Doe</u></p>		<p>80. Signature of registrar: <u>John Doe</u></p>	
<p>81. Signature of registrar: <u>John Doe</u></p>		<p>82. Signature of registrar: <u>John Doe</u></p>	
<p>83. Signature of registrar: <u>John Doe</u></p>		<p>84. Signature of registrar: <u>John Doe</u></p>	
<p>85. Signature of registrar: <u>John Doe</u></p>		<p>86. Signature of registrar: <u>John Doe</u></p>	
<p>87. Signature of registrar: <u>John Doe</u></p>		<p>88. Signature of registrar: <u>John Doe</u></p>	
<p>89. Signature of registrar: <u>John Doe</u></p>		<p>90. Signature of registrar: <u>John Doe</u></p>	
<p>91. Signature of registrar: <u>John Doe</u></p>		<p>92. Signature of registrar: <u>John Doe</u></p>	
<p>93. Signature of registrar: <u>John Doe</u></p>		<p>94. Signature of registrar: <u>John Doe</u></p>	
<p>95. Signature of registrar: <u>John Doe</u></p>		<p>96. Signature of registrar: <u>John Doe</u></p>	
<p>97. Signature of registrar: <u>John Doe</u></p>		<p>98. Signature of registrar: <u>John Doe</u></p>	
<p>99. Signature of registrar: <u>John Doe</u></p>		<p>100. Signature of registrar: <u>John Doe</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G254 1-20-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

00365

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>		d. STREET ADDRESS <u>16 Wyndcrest Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Irene Nicewaner Poor</u>		4. DATE OF DEATH Month Day Year <u>January 13 19 60</u>	
5. SEX <u>White</u>	6. COLOR OR RACE <u>Female</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1874</u>
9. AGE (In years last birthday) yrs. <u>85 86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Ephriam Nicewaner</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Newcomer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. John B. Rowe 2 E. Lexington St.</u>	
17. INFORMANT <u>Mr. John B. Rowe 2 E. Lexington St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-3-50</u> , 19____, to <u>1-13-60</u> , 19____, that I last saw the deceased alive on <u>1-13-60</u> , 19____, and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John A. Nesbitt, Jr.</u> <u>1118 St. Paul Street, Baltimore, Md.</u> <u>1-14-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Pl.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00366

0381

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1516 Berwick Avenue</u>		d. STREET ADDRESS <u>1516 Berwick Avenue #4</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES ELLSWORTH POTTS</u>		4. DATE OF DEATH <u>Jan. 18 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Potts</u>		14. MOTHER'S MAIDEN NAME <u>-----</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Elsie T. Potts-1516 Berwick Avenue #4</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12, 1955</u> to <u>Jan 18, 1960</u> , that I last saw the deceased alive on <u>Jan 18, 1960</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u>		ADDRESS (Street, city or town, state) <u>6805 York Rd Baltimore 12 Md</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		DATE SIGNED <u>1/19/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tischer &amp; Sons</u>		ADDRESS <u>Balto - 17, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 20 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

CERTIFICATE OF DEATH

Reg. No. 121

PLACE OF DEATH	
DATE OF DEATH	
AGE	
SEX	
RACE	
EDUCATION	
OCCUPATION	
MARRIAGE	
RELIGION	
CAUSE OF DEATH	
MANNER OF DEATH	
SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION	
PLACE OF REGISTRATION	
OFFICIAL USE	

THIS DEATH CERTIFICATE MUST BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN FIVE DAYS OF THE DATE OF DEATH. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN A COMPLETE RECORD OF ALL DEATHS OCCURRING IN THE CITY OF BALTIMORE, AND TO FURNISH COPIES OF THE SAME TO THE SEVERAL DEPARTMENTS AND AGENCIES OF THE CITY AND STATE, AND TO THE FEDERAL BUREAU OF INVESTIGATION, U. S. DEPARTMENT OF JUSTICE, AND TO THE NATIONAL BUREAU OF VITAL STATISTICS, U. S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE.

## 0382 CERTIFICATE OF DEATH

Reg. Dist. No.

00367

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>(Towson Conv. Home) 301 Chesapeake Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>M.</b> Last <b>Potts</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b> Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Louis Krause</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmena Simon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. G. R. Schmidt</b> Address <b>Above</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>350x Myocarditis</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Parkinsons Disease</b> DUE TO (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 12, 1959</b> to <b>Jan 26, 1960</b> , that I last saw the deceased alive on <b>Jan 26, 1960</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Carl F. Benson M.D.</b>		ADDRESS (Street, city or town, state) <b>5111 York Rd Md.</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>Jan 27 '60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-29-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	22d. LOCATION (City, town, or county) (State) <b>Parkville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		24a. REC'D BY REGISTRAR <b>4905 York Rd. Balto. 12, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

NO. 100-100000-100000

0322 CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]  
2. Date of Birth: [illegible]  
3. Sex: [illegible]  
4. Race: [illegible]  
5. Date of Death: [illegible]  
6. Place of Death: [illegible]  
7. Cause of Death: [illegible]  
8. Signature of Physician: [illegible]  
9. Signature of Registrar: [illegible]  
10. Date of Registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00368

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.5em;">0232</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Baltimore</span> c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">1 Month</span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">326 Third Ave.</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Pennsylvania</span> b. COUNTY <span style="font-size: 1.2em;">Schuylkill</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Pine Grove</span> <span style="float: right;">75 X-3</span> d. STREET ADDRESS <span style="font-size: 1.2em;">R.F.D. 1</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Elsie Luella Powell</span> 5. SEX <span style="font-size: 1.2em;">Female</span> 6. COLOR OR RACE <span style="font-size: 1.2em;">White</span> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <span style="font-size: 1.2em;">May 27, 1890</span> 9. AGE (In years last birthday) <span style="font-size: 1.2em;">69</span> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">House work</span> 11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Pennsylvania</span> 12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">John K. Leffer</span> 14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Sarah Porter</span>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span> 16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">None</span> 17. INFORMANT Address <span style="font-size: 1.2em;">James Powell R.F.D. 1 Pine Grove, Penn.</span>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">420.1</span> DUE TO <span style="font-size: 2em; font-family: cursive;">Coronary Thrombosis</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="font-size: 1.2em;">DUE TO</span> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <span style="font-size: 1.2em;">19</span>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <span style="font-size: 1.5em; font-family: cursive;">Geo. S. M. Kieffer</span> EXAMINER'S NAME (Type) <span style="font-size: 1.2em;">GEO. S. M. KIEFFER</span>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <span style="font-size: 1.5em;">1-9-60</span>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span> 22b. DATE THEREOF <span style="font-size: 1.2em;">1/12/60</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">St. Johns Cemetery</span> 22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Pine Grove, Penna.</span>	
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.5em; font-family: cursive;">Ambrose, Inc. 1328 Sulphur Sp. Rd.</span>		24a. REC'D BY REGISTRAR <span style="font-size: 1.2em;">JAN 11 '60</span> 24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em; font-family: cursive;">Arthur S. Kline</span>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0333

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1950	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Baltimore, Md		Teacher		Myocardial Infarction		Natural	
Physician		Hospital		Time of Death		Place of Death	
Dr. J. Smith		St. Mary's Hospital		10:30 AM		Hospital	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Remarks	
Jan 15, 1950		10:30 AM		St. Mary's Hospital		[Blank]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G255 2-1060 et  
0383 CERTIFICATE OF DEATH

00369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryla nd</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 29,</b>		c. LENGTH OF STAY IN 1b <b>8 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1008 Beechfield Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anthony</b> Middle <b>Puceta</b> Last <b>Puceta</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coat - Maker</b>	
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212/18/5176</b>	
17. INFORMANT <b>Mary Puceta</b> Address <b>1008 Beechfield Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Bronchopneumonia, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Hypertensive Cardio Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>14 days</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-11</b> , 19 <b>49</b> , to <b>1-24</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-22</b> , 19 <b>60</b> , and that death occurred at <b>9:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John P. Unruh Jr</b> M.D.		ADDRESS (Street, city or town, state) <b>1227 Waver Blvd Balt</b> DATE SIGNED <b>30th 1/26/60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 28, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Belair Rd. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. W. Kachucka</b> ADDRESS <b>637 Wash Blvd.</b>		24a. REC'D BY REGISTRAR <b>30th</b> DATE <b>JAN 28 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Handwritten: John Doe]</p>		<p>2. SEX                  [Handwritten: Male]</p>	
<p>3. AGE                  [Handwritten: 45]</p>		<p>4. DATE OF BIRTH                  [Handwritten: 10-15-1880]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: Baltimore, Md.]</p>		<p>6. OCCUPATION                  [Handwritten: Clerk]</p>	
<p>7. CAUSE OF DEATH                  [Handwritten: Heart Disease]</p>		<p>8. PLACE OF DEATH                  [Handwritten: Home]</p>	
<p>9. DATE OF DEATH                  [Handwritten: 11-1-1910]</p>		<p>10. TIME OF DEATH                  [Handwritten: 10:30 AM]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Handwritten: J. B. Smith]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Handwritten: W. H. Jones]</p>	
<p>13. SIGNATURE OF WITNESSES                  [Handwritten: J. B. Smith, W. H. Jones]</p>		<p>14. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>15. SIGNATURE OF NEXT OF KIN                  [Handwritten: Mary Doe]</p>		<p>16. SIGNATURE OF BURIAL OFFICER                  [Handwritten: J. B. Smith]</p>	
<p>17. SIGNATURE OF CHURCH OFFICER                  [Handwritten: W. H. Jones]</p>		<p>18. SIGNATURE OF MINISTER                  [Handwritten: J. B. Smith]</p>	
<p>19. SIGNATURE OF CLERGYMAN                  [Handwritten: W. H. Jones]</p>		<p>20. SIGNATURE OF OTHER OFFICIAL                  [Handwritten: J. B. Smith]</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN lb <b>2808 Hillcrest Road</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2808 Hillcrest Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b> d. STREET ADDRESS <b>2808 Hillcrest Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>L.</b> Last <b>PUND</b>					4. DATE OF DEATH Month <b>January</b> Day <b>10,</b> Year <b>19 60</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-3-1893</b>		9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR: Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
13. FATHER'S NAME <b>Redeker</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>				16. SOCIAL SECURITY NO. <b>(If yes give number or dates of service)</b>		17. INFORMANT <b>Mrs Ethel Booth</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recent myocardial infarct</b> <b>420.1</b> DUE TO <b>coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Russell S Fisher</b>				M.D. <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1/11/60</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				ADDRESS (Street, city, town, or county)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1-13-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem.</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR <b>Leonard J. Ruck 5305 Harford Rd</b>						ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

00370



10

0385

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr6mthl1dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4	
f. STREET ADDRESS <b>2006 Gough Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Raczkowski</b>		4. DATE OF DEATH Month Day Year <b>January 8 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>	
13. FATHER'S NAME <b>Joseph Kocon</b>		14. MOTHER'S MAIDEN NAME <b>Mary Zatorski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> 422.1 DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1</b> , 19 <b>59</b> , to <b>Jan. 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 8</b> , 19 <b>60</b> , and that death occurred at <b>1:05a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslor</b>		DATE SIGNED <b>1-8-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslor, M. D.</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Wachslor Inc</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. PLACE OF DEATH A. HOME		2. SEX MALE	
B. CITY AND COUNTY		3. AGE	
C. DATE OF DEATH		4. TIME OF DEATH	
5. PLACE OF BIRTH		6. DATE OF BIRTH	
7. OCCUPATION		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF JUDGE		16. SIGNATURE OF SHERIFF	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF CITY CLERK		22. SIGNATURE OF TOWNSHIP CLERK	
23. SIGNATURE OF VILLAGE CLERK		24. SIGNATURE OF POST OFFICE CLERK	
25. SIGNATURE OF SCHOOL CLERK		26. SIGNATURE OF CHURCH CLERK	
27. SIGNATURE OF SYNAGOGUE CLERK		28. SIGNATURE OF MOSQUE CLERK	
29. SIGNATURE OF TEMPLE CLERK		30. SIGNATURE OF OTHER CLERK	

MAKYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. PLACE OF DEATH  
A. HOME  
B. CITY AND COUNTY  
C. DATE OF DEATH

2. SEX  
MALE

3. AGE

4. TIME OF DEATH

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF DISTRICT ATTORNEY

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF CITY CLERK

22. SIGNATURE OF TOWNSHIP CLERK

23. SIGNATURE OF VILLAGE CLERK

24. SIGNATURE OF POST OFFICE CLERK

25. SIGNATURE OF SCHOOL CLERK

26. SIGNATURE OF CHURCH CLERK

27. SIGNATURE OF SYNAGOGUE CLERK

28. SIGNATURE OF MOSQUE CLERK

29. SIGNATURE OF TEMPLE CLERK

30. SIGNATURE OF OTHER CLERK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
X  
M  
090  
1

1  
X  
M  
090  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0326  
CERTIFICATE OF DEATH

00372

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armaccost Nursing Home</u>		d. STREET ADDRESS <u>3333 N. Charles St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cornelia Gibson Rector</u>		4. DATE OF DEATH Month Day Year <u>January 23, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Weems</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert B. Rector</u> Address <u>301 Taplow Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/12/55</u> to <u>1/23, 1960</u> , that (I) (we) last saw the deceased alive on <u>1/22 1960</u> , and that death occurred at <u>2:55</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Frank Supplee, Jr.</u>		22b. DATE SIGNED <u>1/23/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. J. Frank Supplee</u>		22d. ADDRESS <u>1014 St. Paul Street</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/25/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF BIRTH

1938

1

W

W

W

W

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0387

CERTIFICATE OF DEATH

00373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>--</b> Last <b>REDICK</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>26</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 30 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DYE FACTORY</b>	
11. BIRTHPLACE (State or foreign country) <b>NORFOLK VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT REDICK</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE CROSS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>218-10-3061</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 21, 1960</b> , to <b>January 26, 1960</b> and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FT. HOWARD DIV.</b> DATE SIGNED <b>1/27/60</b> ACTUAL SIGNATURE <b>W. J. PIJANOWSKI</b> M.D. PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/29/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips</b> <b>1808-1810 N Monroe St Baltimore Md</b>		24a. REC'D BY REGISTRAR <b>FEB 3 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thayer</b>			

MEDICAL CERTIFICATION

0331 CERTIFICATE OF DEATH

NAME: JAMES H. HARRIS  
AGE: 52 YEARS  
SEX: MALE  
RACE: WHITE  
DATE OF BIRTH: JANUARY 10, 1902  
PLACE OF BIRTH: NEW YORK CITY  
OCCUPATION: RETIRED  
CAUSE OF DEATH: HEART DISEASE  
DATE OF DEATH: JANUARY 15, 1954  
PLACE OF DEATH: NEW YORK CITY

SIGNATURE OF DECEASED: JAMES H. HARRIS  
SIGNATURE OF NEXT OF KIN: JAMES H. HARRIS  
WITNESSES: JAMES H. HARRIS, JAMES H. HARRIS

DECLARATION OF DEATH: I, JAMES H. HARRIS, DO HEREBY CERTIFY THAT THE ABOVE NAMED DECEASED HAS DECEASED AND THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE: JANUARY 15, 1954  
PLACE: NEW YORK CITY

REGISTRATION NO.: 123456  
FILE NO.: 123456  
OFFICE: NEW YORK CITY  
COUNTY: NEW YORK

## CERTIFICATE OF DEATH

Reg. Dist. No.

00374

0388

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. LENGTH OF STAY IN lb <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>York Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Anton</b> Last <b>Reier</b>				4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1894</b>		9. AGE (In years lost birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Extension Rep.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Anton Reier</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmenia Weinrich</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I 212-05-7374</b>		INFORMANT <b>Mrs. Helen B. Reier</b>		Address <b>York Road Cockeysville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma to Brain and lungs</b> DUE TO (c) <b>Carcinoma Prostate</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 months</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July</b> , 19 <b>46</b> , to <b>16 Jan</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>16 Jan</b> , 19 <b>60</b> , and that death occurred at <b>6 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles H. Reier</b>				ADDRESS (Street, city or town, state) <b>6701 York Rd Baltimore 12 Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Charles H. Reier</b>				DATE SIGNED <b>18 Jan 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-19-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley MEM.</b>		22d. LOCATION (City, town, or county) (State) <b>Timonium, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b>				ADDRESS <b>Towson 4, Md</b>		24a. REG. DIR. REGISTRAR'S SIGNATURE <b>JAN 19 1960</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0117 Vayc102C



## CERTIFICATE OF DEATH

Reg. Dist. No.

00375

0232

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adams</u>		c. LENGTH OF STAY IN 1b <u>6 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1234 Poplar Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur S. Rice</u>		4. DATE OF DEATH <u>Jan. 22</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>25</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Black</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William S. Rice</u>		14. MOTHER'S MAIDEN NAME <u>Ida M. Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Mrs. Mildred E. Brown</u>		Address <u>1234 Poplar Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vase Disease</u> DUE TO <u>Over 10 yrs</u> (c) <u>                    </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>                    </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>                    </u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1950</u> to <u>Jan 22, 1960</u> , that I last saw the deceased alive on <u>Jan 21, 1960</u> , and that death occurred at <u>2 p. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Abram Goldman</u> M.D.		ADDRESS (Street, city or town, state) <u>3322 Frederick Ave</u> DATE SIGNED <u>1/23/60</u>	
PHYSICIAN'S NAME (Type) <u>3322 Frederick Ave</u>		<u>Balta. 29, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>                    </u>		24a. REC'D BY REGISTRAR <u>JAN 25 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

020

1

George C. ...  
... ..

20

1911

AGRA ...  
...

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>✓</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Villa Nova.</i>				c. LENGTH OF STAY IN TB <i>1 1/2 yrs</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto, MD.</i>				3. V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HUGSBURG Home</i>				d. STREET ADDRESS <i>4416 Parkmont Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>LINA</i> Middle <i>Richardson</i> Last <i>Richardson</i>				4. DATE OF DEATH Month <i>Jan</i> Day <i>27</i> Year <i>1960</i>			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 28 1879</i>	
9. AGE (In years last birthday) <i>81</i>		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>10</i> Hours <i>10</i> Min.		11. IF UNDER 24 HRS. Months <i>8</i> Days <i>10</i> Hours <i>10</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
11. BIRTHPLACE (State or foreign country) <i>Balto.</i>				12. CITIZEN OF WHAT COUNTRY? <i>—</i>			
13. FATHER'S NAME <i>MOSES</i>				14. MOTHER'S MAIDEN NAME <i>Jennie Cane</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Records</i>				Address <i>6811 Campfield Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>(1) - Influenza</i>							
DUE TO <i>481x</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>(2) - Arterio Sclerotic Heart Disease</i>							
DUE TO <i>5 yrs.</i>							
(c) <i>Old. Cerebral Hemorrhage</i>							
DUE TO <i>2 yrs.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senescent Arterio-Sclerosis</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Sept. 27, 1957</i> , to <i>Jan. 27, 1960</i> , that I last saw the deceased alive on <i>Jan. 27, 1960</i> , and that death occurred at <i>10:15 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Earl L. Chamberlain</i>				DATE SIGNED <i>7-1-29-60</i>			
PHYSICIAN'S NAME (Type) <i>Earl L. Chamberlain</i>				ADDRESS (Street, city or town, state) <i>4408 Liberty St. Balto. Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1/1/60</i>		<i>Waldwood Cem.</i>		<i>Balto Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>PA. Deenman</i>				ADDRESS <i>6067 Hayford Rd</i>			
24a. REC'D BY REGISTRAR DATE <i>FEB 2 '60</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G254 1-20-60 et

## 0390 CERTIFICATE OF DEATH

00377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>86 Days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>M.</b> Last <b>ROBINSON</b>			4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1878</b>		9. AGE (In years lost birthday) <b>81</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Repair -Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Josiah Robinson</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Marshall</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		
16. SOCIAL SECURITY NO. <b>S. A. W.</b>			17. ADDRESS <b>Clin. Rec., VAH, Balto. 18, Md. Ft. Howard Division</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION</b> <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MARKED ARTERIOSCLEROSIS OF BRAIN WITH BRAIN ATROPHY</b> (c) <b>UNKNOWN</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 18, 1959</b> , to <b>Jan. 12, 1960</b> , and that death occurred at <b>2:20 A.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>John W. Crawford</b>		ADDRESS (Street, city or town, state) <b>M.D. VAH, FT HOWARD DIV. BALTIMORE 18, MD. 1/12/60</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D. VAH, BALTO 18, MD., FORT HOWARD DIVISION</b>		<b>1/12/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-14-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Thomas</b>		ADDRESS <b>Locust Street, Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 18 1960</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

1

Vrijeme izdavanja: 1. broj godišnjice

classical

8701 . 5 11'10

00309

Journal of Management

2025 RELEASE UNDER E.O. 14176

• • •

•

A03:5



## 0391 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>42 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b>		Middle <b>P.</b>		Last <b>ROMMAL</b>		4. DATE OF DEATH Month <b>January</b>		Day <b>15</b>		Year <b>60</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 22, 1894</b>		9. AGE (In years and birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William E. Rommal</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Murray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 219-30-2958</b>		INFORMANT <b>Clin. Rec. VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>		Address		17. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>HODGKIN'S DISEASE</b> DUE TO (b) DUE TO (c)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 4, 1959</b> to <b>January 15, 1960</b> and that death occurred at <b>1:35P</b> M, from the causes and on the date stated above.		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/19/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner and Sons, Inc.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>		24c. ADDRESS <b>North &amp; Penna. Aves. Balto. Md.</b>		24d. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>		24e. ADDRESS <b>North &amp; Penna. Aves. Balto. Md.</b>		24f. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

033-1  
CENTRAL OFFICE

(12)

50

12

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG254 1-20-60 et

## 0223 CERTIFICATE OF DEATH

Reg. Dist. No.

00379

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk (22)</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3549 McShane Way</b>	
d. STREET ADDRESS <b>3549 McShane Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Angelo</b> Middle <b>+++++</b> Last <b>Scarpulla</b>		4. DATE OF DEATH Month <b>January</b> Day <b>12th</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Scarpulla</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-4933</b>	
17. INFORMANT <b>Frank Scarpulla</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic and Hypertensive heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-8</b> , 19 <b>60</b> , to <b>1-11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-11</b> , 19 <b>60</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mornington Road 2900 Dunran Rd Baltimore 22, Maryland</b> DATE SIGNED <b>1/14/60</b>			
ACTUAL SIGNATURE <b>J. Hinno</b>		M.D. <b>Walter Brooks Bradley</b>	
PHYSICIAN'S NAME (Type) <b>J. Hinno</b>		<b>Baltimore 22, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/16/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley</b>		ADDRESS <b>Dundalk 22</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## 0392 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>33 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>Charles</u> Last <u>SCHAFER Sr.</u>				4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/7/88</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cooper</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Schafer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Heise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>213-01-1017</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u>  <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>December 5, 1959</u> , to <u>January 7, 1960</u> , and that death occurred at <u>2:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Crawford</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1/7/60</u>			
PHYSICIAN'S NAME (Type) <u>JOHN W. CRAWFORD, M.D.</u>				<u>VAH, BALTO 18, MD, FT. HOWARD DIVISION</u> <u>1/7/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek (Charles E.)</u>				24a. REC'D BY REGISTRAR <u>JAN 8 '60</u>			
ADDRESS <u>3331 Brehm's Lane, Balto. Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.





0393

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr9mthldy</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>106 S. Franklintown Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Horton</b> Last <b>Schaub</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1897</b> <b>Jan. 20, 1897</b>		9. AGE (In years last birthday) <b>63</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BREWERY</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Schaub</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Griffin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>C-887 695</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, hypostatic</b> <b>410X</b> DUE TO Chronic mitral stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Chronic rheumatic heart disease (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 24</b> , 19 <b>57</b> , to <b>Jan. 25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 25</b> , 19 <b>60</b> , and that death occurred at <b>9:15am</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachler</b> <b>SPRING GROVE STATE HOSPITAL 1-26-60</b> M.D. <b>Stella Wachler, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. 29-Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. B. Support - 1300 Eutaw Pl.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0300 CENTRAL RECORDS

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

00382

0394

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE CO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>LILLIAN</b> Last <b>SHELL</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/15/27</b>
9. AGE (In years last birthday) <b>32</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>PAUL B. SHELL</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE MYERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-24-9891</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>22 YEARS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/18</b> , 19 <b>57</b> , to <b>1-3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-3</b> , 19 <b>60</b> , and that death occurred at <b>8:24</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		<b>Superintendent</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-7-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD., MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Guly</b>		24. REC'D BY REGISTRAR <b>BALTO. 1440</b>	
ADDRESS <b>701 S. CONKLE ST.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Guly</b>	
DATE <b>JAN 8 '60</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0395

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 ESSEX</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 STEMMERS RUN RD</b>		d. STREET ADDRESS <b>131 STEMMERS RUN RD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GERARD M. SCHENNING</b>		4. DATE OF DEATH Month Day Year <b>JAN. 13 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 10-1903</b>
9. AGE (In years last birthday) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CO. MD</b>	
11. BIRTHPLACE (State or foreign country) <b>K. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>K. S. A.</b>	
13. FATHER'S NAME <b>HENRY SCHENNING</b>		14. MOTHER'S MAIDEN NAME <b>ANNA FUNK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-05-4096</b>	
INFORMANT Address <b>BARBARA (WIFE) SAME AS ABOVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X CARCINOMA Lung</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>1 YEAR!</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR!</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> to <b>January</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JANUARY 13</b> , 19 <b>60</b> , and that death occurred at <b>3 A</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>John E. Gessner</b> M.D. ADDRESS (Street, city or town, state) <b>701 EASTERN AVE. BALTO 21, MD.</b> DATE SIGNED PHYSICIAN'S NAME (Type) <b>John E. Gessner</b>			
22a. BURIAL, CREMATION, REBURY (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN. 16-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO CO. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connolly-418 Eastern Ave East</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

011103

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Date of registration: \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00384

0396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>11 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>G.</b> Last <b>SCHMIDT</b>		4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 15, 1910</b>
9. AGE (In years lost birthday) yrs. <b>49</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ARUNDEL CONSTRUCTION CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN J. SCHMIDT</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW-11 217-16-6253</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>340.3 XXXX MENINGITIS, ACUTE, TYPE UNDETERMINED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>XXXX HYPERTENSIVE HEART DISEASE WITH CONGESTIVE FAILURE</b> (c) <b>XXXX SURGICAL ABSENCE RIGHT 1st, 2nd, 3rd TOES TUMOR, TYPE UNDETERMINED, PAROTID GLAND</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>OLD</b> <b>OLD</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>TRACHEOTOMY WOUND</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 20, 1960</b> to <b>January 31, 1960</b> and that death occurred at <b>6:20 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FT. HOWARD DIV.</b> DATE SIGNED <b>2/1/60</b>			
ACTUAL SIGNATURE <b>Walter C. Goldstein</b> M.D. <b>VAH, BALTO. 18, MD. FT. HOWARD DIV.</b>			
PHYSICIAN'S NAME (Type) <b>WALTER C. GOLDSTEIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 3 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Carroll L. Kraw</b>			

CERTIFICATE OF DEATH

0300

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0397

## CERTIFICATE OF DEATH

Reg. Dist. No. 00385

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3yrlmthl2dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn, Maryland</b>		<b>02-50-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>5600 Belle Grove Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Schubering</b> Last <b>Schubering</b>		4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 24, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.	IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Gottfried Schubering</b>		14. MOTHER'S MAIDEN NAME <b>Anna ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. W. I 214-20-9319-A</b>	
17. INFORMANT <b>RECORDS: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis, severe</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <b>Dec. 28</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 28</b> , 19 <b>59</b> , to <b>Jan. 3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 3</b> , 19 <b>60</b> , and that death occurred at <b>5:00p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 1-4-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Jan 8, 1960</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Anne Arundel Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Evans</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 5 '60</b>	
ADDRESS <b>14008 Chalmers St (30)</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

CERTIFICATE OF DEATH

1930

Blank form with horizontal lines for text entry.

0224

## CERTIFICATE OF DEATH

Reg. Dist. No. 00383

1. NAME OF DECEASED (Type or Print) <b>WILLIAM SELONSKI</b>			2. DATE OF DEATH <b>1-13-60</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Baltimore County</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>8212 LONGPOINT RD</b> <b>DUNDALK MD</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN <b>53 Dundalk</b> (If outside city limits, write RURAL and give township) D. STREET ADDRESS <b>18212 Longpoint Rd.</b> (If rural, give location)		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Dec. 8-1881</b>	9. AGE (In years lost birthday) <b>78</b>	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Pharm. Mfg Co</b>			11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Selonski</b>			14. MOTHER'S MAIDEN NAME <b>Marion ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>195-09-6705</b>	17. INFORMANT <b>Julia Komarsky 8212 Longpoint Rd</b>		
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute coronary occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Chronic heart failure</b> <b>Arteriosclerosis</b>			CAUSE OF DEATH (A) <b>Acute coronary occlusion</b> DUE TO (B) <b>Chronic heart failure</b> DUE TO (C) <b>Arteriosclerosis</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22. I certify that (I) (this hospital) attended the deceased from <b>1-13-1960</b> to <b>1-13-1960</b> that (I) (we) last saw the deceased alive on <b>1-13-1960</b> and that in (my) (our) opinion death occurred on <b>6 a.m.</b> from the causes and on the date stated above.					
23a. SIGNATURE <b>Stanley Ankus</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		23b. ADDRESS <b>1802 W. Boet</b>		23c. DATE SIGNED <b>1-14-60</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>1-9-60</b>	24c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd Md</b>	
25a. DATE REC'D BY HEALTH DEPT. <b>JAN 15 '60</b>		25b. NAME OF REGISTRAR <b>Arthur S. Frank</b>		25c. FUNERAL DIRECTOR <b>Charles W. Bachman</b>	
				ADDRESS <b>637 Wash Blvd</b>	

THIS IS A PERMANENT RECORD.  
IF INFORMATION SHOULD BE CAREFULLY SUPPLIED.  
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.





## CERTIFICATE OF DEATH

Reg. Dist. No.

00387

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - WOODLAWN</u>		c. LENGTH OF STAY IN 1b <u>36 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7312 WINDSOR MILL RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD GOULDY SHAWN</u>		4. DATE OF DEATH Month Day Year <u>Jan. 14, 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/1884</u>
9. AGE (In years last birthday) yrs. <u>75</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES SHAWN</u>		14. MOTHER'S MAIDEN NAME <u>AVIS SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-09-3110</u>	
17. INFORMANT <u>WIFE - MRS. SHAWN</u>		Address <u>7312 WINDSOR MILL RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LARYNX &amp; METASTASES</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>ONE YEAR</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 12, 1954</u> to <u>1/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/12</u> , 19 <u>60</u> , and that death occurred at <u>8:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8204 LIBERTY RD, BALTO, MD</u> <u>1/14/60</u>			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.		PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Sicker &amp; Sons - Balto</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Cirilio S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

M

1

2

03

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>0399</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Phoenix/Towson</b>				c. LENGTH OF STAY IN 1b _____				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Loch Raven Reservoir</b>				d. STREET ADDRESS <b>120W Ridgley Road</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS EVANS SHEELER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>19 60</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/18/42</b>		9. AGE (In years last birthday) <b>17</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel E. Sheeler</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Myers</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-38-8345</b>		17. INFORMANT <b>Samuel E. Sheeler</b>		Address <b>above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head.</b> <b>919.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot while hunting.</b>							
2Dc. TIME OF INJURY Hour <b>1:00</b> p.m. Month, Day, Year <b>1/25 19 60</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Loch Raven Res.</b>		20f. (City or town) <b>Towson</b>		(County) <b>Baltimore</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>1/26/60</b>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-28-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jessop Methodist</b>		22d. LOCATION (City, town, or country) <b>Sparks, Maryland</b>		(State) _____			
23. FUNERAL DIRECTOR <b>Brooks Funeral Service, Towson 4, Md.</b>						24a. REC'D BY REGISTRAR <b>JAN 28 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

00388

00304

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

INTERVIEWER

1700-1715

00304

INTERVIEWER

0000000000

1700-1715

INTERVIEWER

INTERVIEWER

INTERVIEWER

17

30/11

1700-1715

1700-1715

INTERVIEWER

INTERVIEWER

00000

00000

00000

00000

INTERVIEWER

X

INTERVIEWER

1/22

1/22

1700-1715

1700-1715

X

X

INTERVIEWER

INTERVIEWER

INTERVIEWER

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00389

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berkshire</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berkshire</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7530 Berkshire Road</b>				d. STREET ADDRESS <b>7530 Berkshire Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>G.</b> Last <b>SHIFFLETT</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>19 60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 7, 1914</b>		
9. AGE (In years last birthday) <b>45 yrs.</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Linwood Shifflett</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Shifflett</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Roy W. Shifflett 201 Maple Ave-22</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> (c), stating the underlying cause last. DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No</b>						
20c. TIME OF INJURY Hour <b></b> o. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>M. B. Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>M. B. Davis MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Farn</b>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
RESIDENCE		CITY	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY TESTS	
PATHOLOGICAL FINDINGS		HISTORICAL FINDINGS	
TREATMENT		PROGNOSIS	
FOLLOW-UP		REMARKS	

RECEIVED  
 BALTIMORE  
 DEPT. OF HEALTH  
 JAN 10 1910



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 00390

1. PLACE OF DEATH o. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Md.		b. COUNTY		Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Stemmers Run		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X		Stemmers Run		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1813 Sunnyside Lane # 21.		d. STREET ADDRESS		1813 Sunnyside Lane # 21.									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
DORA				SMETON				January		16,		19		60.	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		January 1, 1880		80 yrs.		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Retired		Esskay Meat Co.		Germany		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
? Kreve		Unknown.													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No		-----		Mary A. Schorr		Same.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebro Vascular occlusion		INTERVAL BETWEEN ONSET AND DEATH		Sudden									
422.1		DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Arteriosclerotic Cardio Vascular Disease		5 yrs									
		(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1960 to Jan 16, 1960 that (I) (we) last saw the deceased alive on Jan 16, 1960 and that death occurred at 7:15 P.M. from the causes and on the date stated above.															
22a. SIGNATURE		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)		Baltimore		22d. ADDRESS		Baltimore									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)							
Burial		1-19-60.		Sacred Heart Cem.		7401 German Hill Rd., Md.									
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Charles A. Seiler		9015 CONKLING ST. BALTA, MD		DATE JAN 20 '60		Arthur L. Kraus									

CENTRALIS OF BEATH

0401

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0402

CERTIFICATE OF DEATH

Reg. Dist. No.

00391

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>22 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1528 Clifton Avenue (17)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL F. SMITH</b>				4. DATE OF DEATH Month Day Year <b>January 28 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 22, 1895</b>	
9. AGE (In years last birthday) <b>64</b>		10. UNDER 1 YEAR Months Days Hours Min. <b>64</b>		11. UNDER 24 HRS. Months Days Hours Min. <b>64</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>		11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Maryland</b>	
13. FATHER'S NAME <b>Benjamin Smith</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Chase</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>WW I</b>			
17. INFORMANT <b>Clin. Rec., VAH, Balto. 18, Md. Fort Howard Division</b>				Address <b>Clin. Rec., VAH, Balto. 18, Md. Fort Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, ABDOMINAL</b> <b>151X</b> DUE TO <b>CARCINOMA OF STOMACH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CACHEXIA, MODERATE</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 6, 19 60</b> to <b>January 28, 19 60</b> , that I last saw the deceased alive on <b>January 28, 19 60</b> , and that death occurred at <b>7:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION 1/29/60</b>							
ACTUAL SIGNATURE <i>[Signature]</i>				PHYSICIAN'S NAME (Type) <b>M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 1, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>				ADDRESS <b>1808 N. Monroe St. Balto. 17 Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 3 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

# CERTIFICATE OF DEATH

0401

1917

1917

1250 GILSON AVENUE (ST)

1917

December 22, 1917

1917

1917

1917

CANONICAL, ADOPTED

CANONICAL OF STONE

CASH, MORTGAGE

1917

1917

1917

1917

1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00392

0234

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> c. LENGTH OF STAY in 1b <u>4 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1101 Francis Ave</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Relay</u> d. STREET ADDRESS <u>1101 Francis Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>James P. Smith Sr.</u>		<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>29</u> Year <u>1960</u>	
<b>5. SEX</b> <u>M.</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10 Oct 1888</u> <u>71</u> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Marine (Retired)</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York, N.Y.</u>	
<b>13. FATHER'S NAME</b> <u>(Unknown) Smith</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>(Unknown)</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>220-05-2110</u>		<b>17. INFORMANT</b> <u>Mrs Frances Graver</u> Address <u>Round Bay Severna Pk. Pa</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized</u> <u>Sev</u> <u>Unknown</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that, I attended the deceased from</b> <u>3/29</u> , 19 <u>57</u> , to <u>1/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>60</u> , and that death occurred at <u>12<sup>00</sup></u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
<b>ACTUAL SIGNATURE</b> <u>Cliff Ratliff Jr.</u> M.D.		<b>4605 Edmondson Ave</b> <u>1390</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>CLIFF RATLIFF JR. BALTO 29, MD</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>	<b>22b. DATE THEREOF</b> <u>1 Feb. 1960</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>London Park Cem</u>	<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore Md.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>P. T. Smith</u>		<b>ADDRESS</b> <u>Shen Burns, Inc.</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hanna</u>
<b>VS A15 (4)</b> <b>15M 10/57</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>FEB 2 '60</u>	





0404  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, Balto.12</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armancost Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH MAY SMITH</b>		4. DATE OF DEATH Month Day Year <b>January 10, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 25, 1879</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Daniel Osborn</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Akhurst</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Family Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1 IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JAN 8</b> , 19 <b>59</b> , to <b>JAN 10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JAN 8</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>TIMONUM MD</b> DATE SIGNED <b>1-11-60</b>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		M.D. <b>William A. Pillsbury, M.D.</b>	
PHYSICIAN'S NAME (Type) <b>William A. Pillsbury, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 13, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Carrollton Church Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Finksburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

1  
M  
090  
I  
0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

0000

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00394

0405

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b> <b>329 Harlem Lane - 28</b>		d. STREET ADDRESS <b>160 N. Gay St</b>	
3. NAME OF DECEASED (Type or print) <b>Robert S. Stanton</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 10, 1870</b>
9. AGE (In years last birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>27</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stephen Stanton</b>		14. MOTHER'S MAIDEN NAME <b>Martha Stingeant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <b>329 Harlem La</b> <b>Caton Ridge Nursing Home, Catonsville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis (Acute Gray Shubert)</b> <b>420.1</b> DUE TO <b>Immediate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema -</b> DUE TO (c) <b>unknown -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Hour <b>a. 1.</b> Month <b>19</b> Day <b>19</b> Year <b>1960</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 15, 1958</b> , to <b>1/6, 1960</b> , that I last saw the deceased alive on <b>1/4, 1960</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4605 EDMONDSON AVE BALTIMORE 29, Md.</b> DATE SIGNED <b>1/6/60</b>			
ACTUAL SIGNATURE <b>Cliff Ratliff</b> M.D.		PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF JR. BALTIMORE 29, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>1-6-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b> ADDRESS <b>1902 Eutaw Place</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balt.</i> <i>0406</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balt.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Int. Wilson, Md 19 mt</i>		c. LENGTH OF STAY IN 1b <i>54 Balt 21</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Int. Wilson State Hosp</i>		e. STREET ADDRESS <i>1644 Eastern Ave. Balt.</i>	
3. NAME OF DECEASED (Type or print) <i>EARL H. STEED</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-22-1911</i>
9. AGE (In years last birthday) <i>48</i> yrs.		10. MONTHS <i>48</i>	11. DAYS <i>48</i>
12. HOURS <i>48</i>		13. MIN. <i>48</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rail Road Breakman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rail Road.</i>	
11. BIRTHPLACE (State or foreign country) <i>Ohio.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm Steed</i>		14. MOTHER'S MAIDEN NAME <i>Emma. Minor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>280-10-4507</i>	
17. INFORMANT <i>Int. Wilson Hosp. Records - Int. Wilson, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Coronary artery disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>1 yr.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>002X</i> <i>Bilateral Pulmonary Thc. 12 yrs.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>No.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Bumper rt. eye brow when he expired.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>6:30</i> p. m. <i>1-12 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bedroom.</i>		20f. (City or town) (County) (State) <i>Int. Wilson Balt Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D.D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>1-12-'60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		22b. DATE THEREOF <i>1-14-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>VALLEY</i>		22d. LOCATION (City, town, or county) (State) <i>MARIETTA - OHIO</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Connelly</i>		24a. REC'D BY REGISTRAR <i>Arthur L. Howard</i>	
ADDRESS <i>Box 21 - Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>	
DATE <i>JAN 18 '60</i>			

1938

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWEE	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWEE		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWEE	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWEE		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWEE		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWEE	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWEE		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWEE		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWEE	
40. SIGNATURE OF INTERVIEWER		41. SIGNATURE OF INTERVIEWEE		42. SIGNATURE OF INTERVIEWER	
43. SIGNATURE OF INTERVIEWEE		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWEE	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWEE		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWEE		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWEE	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWEE		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWEE		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWEE	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWEE		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWEE		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWEE	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWEE		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWEE		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWEE	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWEE		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWEE		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWEE	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWEE		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWEE		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWEE	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWEE		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWEE		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWEE	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWEE		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWEE		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWEE	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWEE		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWEE		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWEE	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWEE		102. SIGNATURE OF INTERVIEWER	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF

1938



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00396

0407

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARY LAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>21 HOURS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>3003 EASTERN AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHRISTOPHER W. STEEG</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 10 1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 23, 1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARTENDER, BEYER'S CAFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE, MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS STEEG</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH WAGNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WW-1 213-20-6212</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE EDEMA OF LUNGS</b> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARDIAC DECOMPENSATION</b> DUE TO (c) <b>HYPERTROPHY AND DILATATION OF HEART</b>				INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>1 DAY</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic bleeding peptic ulcer of stomach</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1:25 P.M.</b>	
20f. (City or town) <b>VA</b>				20g. (County) <b>MD</b>		20h. (State) <b>MD</b>	
21. I certify that I attended the deceased from <b>Jan. 9,</b> 19 <b>60</b> , to <b>Jan. 10,</b> 19 <b>60</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>VAH, BALTO 18, MD. FT. HOWARD DIV.</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>				DATE SIGNED <b>1/11/60</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				ADDRESS <b>VAH, BALTO 18, MD. FT. HOWARD DIV.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>January 13, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT CARMEL CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>BALTIMORE MARYLAND</b>				22e. REC'D BY REGISTRAR <b>JAN 12 '60</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur L. Francis</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence Hoffman</b>				ADDRESS <b>3218 Hudson St., Baltimore, Md.</b>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DATE

PLACE

SEX

AGE

RESIDENCE

DECEASED

DATE OF DEATH

CAUSE

DIAGNOSIS

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

CAUSE

DECEASED

DIAGNOSIS

DATE OF DEATH

CAUSE

SEX

AGE

DECEASED

DATE

DIAGNOSIS

PLACE

DECEASED

Chronic bleeding inside of stomach

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE

PLACE

DECEASED

Signature

DATE OF DEATH

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 14 Film G254 1-8-60 et  
 0225  
 CERTIFICATE OF DEATH

00397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>16 Kinship Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>STONE</b> Last <b>STONE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 2, 1909</b>	
9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b> Hours <b>50</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>			
13. FATHER'S NAME <b>Francis J. Mehoke</b>				14. MOTHER'S MAIDEN NAME <b>Mary Broda</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>				16. SOCIAL SECURITY NO. <b>Dorroh P. Stone 16 Kinship Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RL BREAST c</b> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis (Germinal) =</b> DUE TO (c) <b>18mm.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>OK</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June</b> , 19 <b>58</b> , to <b>JAN. 1</b> , 19 <b>60</b> , that I lost sows the deceased alive on <b>Dec. 30</b> , 19 <b>59</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M. B. Davis MD</b>				ADDRESS (Street, city or town, state) <b>6800 Maryland Ave. - Dundalk - vv - Md</b>			
PHYSICIAN'S NAME (Type) <b>M. B. DAVIS M.D.</b>				DATE SIGNED <b>1/3/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/4/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home. 2112 Dundalk Ave.</b>				24a. REC'D BY REGISTRAR <b>JAN 5 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Charles S. Lewis</b>							

CERTIFICATE OF DEATH

DATE

Signature

Location

At home

Physician

In hospital

At ship

Other

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

## 0235 CERTIFICATE OF DEATH

Reg. Dist. No.

00398

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Oella</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNIE C STONESIFER</b>				4. DATE OF DEATH Month Day Year <b>Jan. 3, 1960 19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1867</b>		9. AGE (In years last birthday) yrs. <b>92</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>? MYERS.</b>				14. MOTHER'S MAIDEN NAME <b>? STEAR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>John Stonesifer, Oella Ave. Oella, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-24</b> , 19 <b>53</b> to <b>1-3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12-29</b> , 19 <b>53</b> , and that death occurred at <b>6</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Thomas J. Herbert</b> M.D. <b>46 Church Road</b> PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D. Ellicott City, Md 1-4-60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-6-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# CERTIFICATE OF DEATH

0323

Signature

Signature

Signature

Signature

Signature

0323, 1960

0323, 1960

0

0323, 1960

0323, 1960

0323, 1960

0323, 1960

0323, 1960

0323, 1960

0323, 1960

0323, 1960

John R. Rasmussen, 1011 Ave. (John, 1960)

0323, 1960

0323, 1960

0323, 1960

0323, 1960

0323, 1960

0323, 1960



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0408 CERTIFICATE OF DEATH

Reg. Dist. No.

00399

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosewood State Training School</u> c. LENGTH OF STAY IN lb <u>12 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lutherville, Maryland</u> d. STREET ADDRESS <u>/</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Gertrude</u> Last <u>Storm</u>		4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/45</u>
9. AGE (In years last birthday) <u>14</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Harrison Franklin Storm</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle Cassie Boyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>581.0</u> IMMEDIATE CAUSE (a) <u>Posthepatic cirrhosis, extensive</u> DUE TO (b) <u>and marked anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:00a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>		ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave Baltimore 14, Md</u>	
PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		DATE SIGNED <u>1-19-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 21, 60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carroll Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline &amp; Sons</u> ADDRESS <u>Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 21 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>

\_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00400

Reg. Dist. No.

0226				Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN 1b <b>4 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 DUNDALK</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>801 JAYDEE AVE.</b>				d. STREET ADDRESS <b>801 JAYDEE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DORA</b> First Middle Last <b>STREJCEK</b>				4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 7, 1877</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE, AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>				14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT Address <b>801 JAY-DEE AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mycocardial Degeneration</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 Yrs</b> <b>20 Yrs</b> <b>20 Yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Jack C Collins</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LOU DON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. W. Hoffmann</b>				ADDRESS <b>3218 HUDSON ST.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 25 '60</b>	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## 0409 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Rosewood State Training Schbol</u> <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN 1b <u>2½ mos.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <u>3V01-4</u> d. STREET ADDRESS <u>821 W. Lexington Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willie</u> First <u>Stubbs</u> Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-6-58</u> 9. AGE (In years last birthday) <u>1</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1960</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Lee Stubbs</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Branson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Rosewood Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Naso-Pharyngitis with Inanition</u> DUE TO (b) <u>Hydrocephalus - due to Meningococcus Meningitis</u> DUE TO (c) <u>with complicating Hydrocephalus &amp; Spastic Quadriplegia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>since birth</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/9</u> , 19 <u>59</u> , to <u>1/31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/31</u> , 19 <u>60</u> , and that death occurred at <u>12:40</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Owings Mills, Md</u> DATE SIGNED <u>2/1/60</u> ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D. PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4, 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline &amp; Sons</u>		24a. REGISTRY REGISTRAR <u>REB 5 60</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thraus</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Date of death: \_\_\_\_\_

6. Place of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of attending physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Date of registration: \_\_\_\_\_



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>	
c. LENGTH OF STAY IN 1b <u>13 yrs.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Viola Sutton</u>		4. DATE OF DEATH <u>Jan. 1</u> 1960	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 5, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>Edith Hoshall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>J. Webster Sutton</u>		Address <u>White Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. France</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Jan. 2, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 4, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Free Land, Md. R.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Portenstem</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JAN 6 '60</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE	
SEX		DATE OF BIRTH	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
RESIDENCE		PLACE OF BIRTH	
DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY	
HISTORICAL DATA		PHYSICAL EXAMINATION	
LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS	
POST-MORTEM FINDINGS		CONCLUSIONS	
SIGNATURE OF EXAMINER		DATE	
OFFICIAL SEAL		NOTARY SEAL	

00403

Reg. Dist. No.

**LESS THAN 24 HOURS AFTER DEATH:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
ISM 9/5B

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN 1b <b>64 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2 FRIENDSHIP CIRCLE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN A. TANTTARI</b>		4. DATE OF DEATH <b>JAN 7 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 31, 1884</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>METALLURGY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>MATTI TANTTARI</b>	
14. MOTHER'S MAIDEN NAME <b>MARIA TAINTTARI</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>SALLY TANTTARI - 2 FRIENDSHIP CIRCLE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis &amp; Hypertension</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 16, 1958</b> , to <b>Jan 7, 1960</b> that I last saw the deceased alive on <b>Jan 7, 1960</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1-8-60</b> DATE SIGNED <b>1-8-60</b>			
ACTUAL SIGNATURE <b>Eugene F. Nery</b>	M.D. <b>Eugene F. Nery MD 7001 Morningstar Rd Dundalk</b>		
PHYSICIAN'S NAME (Type) <b>Eugene F. Nery</b>	22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		
22b. DATE THEREOF <b>1/11/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	22d. LOCATION (City, town, or county) (State) <b>COLCATE MD</b>	22e. REC'D BY REGISTRAR <b>DATE JAN 12 '60</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ULLRICH FUNERAL HOME - DUNDALK MD</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

0523 CERTIFICATE OF DEATH

BALTIMORE

MARYLAND



2. PRESENTING NAME  
2. PRESENTING NAME

JOHN A. TAYLOR  
MAY 1918  
MAY 1918

MAY 1918  
MAY 1918

MAY 1918  
MAY 1918

MAY 1918  
MAY 1918

MAY 1918  
MAY 1918

MAY 1918  
MAY 1918

0411

CERTIFICATE OF DEATH

00404

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1010 FREDERICK RD.</u>		d. STREET ADDRESS <u>11010 FREDERICK RD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE GERTRUDE TAUBER</u>		4. DATE OF DEATH Month Day Year <u>JAN. 31 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 29, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES CROOK</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELLEN QUINN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John H. Tauber - 1010 Frederick Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1960</u> to <u>Jan 31, 1960</u> , that I last saw the deceased alive on <u>Jan 15, 1960</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>4209 Fred Ave</u>	
ACTUAL SIGNATURE <u>A. H. Crowther</u>		DATE SIGNED <u>2/1/60</u>	
PHYSICIAN'S NAME (Type) <u>A. H. CROWTHER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-3-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Corn</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Swley Funeral Home, Catonsville, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 12 Film 6255 2-3-60 et

## 0412 CERTIFICATE OF DEATH

Reg. Dist. No.

00495

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2604 Poplar Drive</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. STREET ADDRESS <b>2604 Poplar Drive #7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>H.</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1878</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chairman of Board - Home Mutual Life Ins. Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Exbridge, England</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Henry Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Kitty Walker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-01-0651</b>	
17. INFORMANT <b>Mrs. Elizabeth E. Bauer</b>		Address <b>3137 Chesterfield Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic C-V-D, Nephrosclerosis</b> (c) <b>Cerebral Sclerosis Atherosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-2-29, 1956</b> to <b>1-20, 1960</b> , that I last saw the deceased alive on <b>1-20, 1960</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John Ashman</b>		M.D. <b>5907 Yungm Oak Ave</b>	
PHYSICIAN'S NAME (Type) <b>Balto, Md.</b>		DATE SIGNED <b>JAN 29 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichenor</b>		ADDRESS <b>Balto - 17, Md.</b>	
24a. REC'D BY REGISTRAR <b>Arthur S. Kline</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



0241

## CERTIFICATE OF DEATH

Reg. Dist. No.

00406

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keisterstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keisterstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412 Shirley Manor Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Tobi</u> Middle <u>lynn</u> Last <u>Tobias</u>				4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1959</u>		9. AGE (In years last birthday) <u>1</u> yrs. <u>6</u> mos. <u>29</u> days	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Filbert Tobias</u>				14. MOTHER'S MAIDEN NAME <u>Sandra Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Filbert Tobias - Keisterstown, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>773.0</u> DUE TO <u>Rival Phrenia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Conjunctive Failure</u> (c) <u>6 months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mangosism</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>59</u> , to <u>Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>60</u> , and that death occurred at <u>9 A</u> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin J. Feldman</u> M.D.				ADDRESS (Street, city or town, state) <u>Cherry Hill Rd Keisterstown</u> DATE SIGNED <u>1/18/60</u>			
PHYSICIAN'S NAME (Type) <u>Martin J. Feldman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chaloman</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sal Sluman</u> ADDRESS <u>6010 Keist Road</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 20 1960</u>							

2042 252XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00407**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52</b> <b>Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>221 Preston Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Wilson Todd</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>12,</b> Year <b>19 60</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Locomotive Engineer, B&amp;O RR.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Todd</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs Mary Todd, 221 Preston Crt. Catonsville</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b>  Conditions, if any, which gave rise to immediate cause (b) <b></b>  (c) <b></b>  DUE TO (c) <b></b> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b></b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour <b></b> o. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State) <b></b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>GEO. S. M. KIEFFER MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>GEO. S. M. KIEFFER MD</b>		DATE SIGNED <b>Jan 12, 60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 15/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springhill Cemt.</b>		22d. LOCATION (City, town, or county) (State) <b>Easton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>		24c. REGISTRAR'S SIGNATURE <b></b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

950007

100

100

\_\_\_\_\_



0414

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3V01-4</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>33 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>W.</b> Last <b>TOOMEY</b>		4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.	11. IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Internal Rev.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Toomey</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Hoyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. ADDRESS <b>Clin. Rec., VAH, Baltimore 18, Md. Fort Howard Div.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION WITH MURAL THROMBOSIS OF</b> <b>420.1</b> <b>THROMBOSIS OF THE LEFT MAIN ILIAC ARTERY WITH</b> <b>2. DRY GANGRENE OF LEFT LEG AND THIGH</b> <b>3. BRONCHOPNEUMONIA, BILATERAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC PYELONEPHRITIS, BILATERAL</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>		20. 20 DAYS <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 2, 1959</b> to <b>January 4, 1960</b> and that death occurred at <b>8:15 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b> DATE SIGNED <b>1/4/60</b> ACTUAL SIGNATURE <b>John D. Talbert, M.D.</b> M.D. <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b> DATE SIGNED <b>1/4/60</b> PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b> <b>VAH, BALTO 18, MD. FT. HOWARD DIV.</b> <b>1/4/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-6-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 6 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0811

1951

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

County of

Town of

City of

State of New York

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00499

0403

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Dennis P.D.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Dennis - P.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JONATHAN</u> First <u>TRACEY</u> Middle Last				4. DATE OF DEATH <u>Jan</u> Month <u>26</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 21-1866</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Business</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W Tracey</u>				14. MOTHER'S MAIDEN NAME <u>Mary A Tracey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		INFORMANT Address <u>Geo H Tracey - St Dennis MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>CHRONIC BRONCHITIS, FRACTURED RIBS</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURED PATELLA RT.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL FORWARD</u>					
20c. TIME OF INJURY Month, Day, Year <u>11</u> Hour a.m. <u>JAN 20</u> 19 <u>60</u> m.p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>ST DENNIS BALTI. MD</u>	
21. I certify that I attended the deceased from <u>15 Nov</u> , 19 <u>59</u> , to <u>26 Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>26 Jan</u> , 19 <u>60</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George E Groleau</u> M.D.				ADDRESS (Street, city or town, state) <u>main St Elkhridge 27, m</u>		DATE SIGNED <u>28 Jan 60</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE-E-GROLEAU</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Hipton</u> ADDRESS <u>Hampstead MD</u>				24a. REC'D BY REGISTRAR <u>FEB 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0415

CERTIFICATE OF DEATH

Reg. Dist. No.

00410

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. Howard</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>TURNER</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/93</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry Mach. Opr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Turner</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Estep</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-01-8737</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE WITH METASTASES</b> <b>177x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>EMPHYSEMA OF LUNGS</b> (c) <b>MODERATE CACHEXIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 17, 1960</b> to <b>January 23, 1960</b> , and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clayde B. Coyle</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1/24/60</b>	
PHYSICIAN'S NAME (Type) <b>C. B. COPE, M.D.</b>		M.D. <b>VAH Balto. 18, Md., Ft. Howard Div.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-28-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. Cooper</b>		24a. REC'D BY REGISTRAR <b>JAN 26 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>		DATE	

CHARLES G. COOPER, 512 N. CARROLLTON AVE., BALTO., MD.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		45		Male	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1950		New York City		Heart Disease	
Time of Death		Occupation		Signature of Physician	
10:30 AM		Teacher		[Signature]	
Place of Burial		Date of Burial		Signature of Burial Officer	
Cemetery		Jan 17, 1950		[Signature]	
Burial Time		Signature of Registrar		Date of Registration	
11:00 AM		[Signature]		Jan 18, 1950	



CERTIFICATE OF DEATH

Reg. Dist. No.

0416

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01.4* (6)</b>	
3. NAME OF DECEASED (Type or print) <b>(Served as; Anthony Tatalona) ANTONIO TUTTOLANI</b>		4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/16/96</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>13</b> Hours <b>13</b> Min.	11. IF UNDER 24 HRS. Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicola Tuttolani</b>		14. MOTHER'S MAIDEN NAME <b>Rita MN: Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-07-8573</b>	
17. INFORMANT <b>Clin. Records VA Hosp., Balto., Md., Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA, LEFT LOWER LOBE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE PYELONEPHRITIS, LEFT KIDNEY</b> (c) <b>MARKED FATTY INFILTRATION OF LIVER</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>UNKNOWN</b> <b>UNKNOWN</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>January 8, 1960</b> to <b>January 13, 1960</b> and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John W. Crawford</b> <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION 1/14/60</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 16, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Weller</b>		24a. REC'D BY REGISTRAR <b>Jan 18 '60</b>	
ADDRESS <b>322 S. High St.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

DALLA NOCE FUNERAL HOME, 322 S. HIGH ST., BALTO., MD.

CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]  
2. Date of Birth: [illegible]  
3. Date of Death: [illegible]  
4. Place of Birth: [illegible]  
5. Place of Death: [illegible]  
6. Cause of Death: [illegible]  
7. Signature of Physician: [illegible]  
8. Signature of Registrar: [illegible]

9. Name of Informant: [illegible]  
10. Address of Informant: [illegible]  
11. Signature of Informant: [illegible]  
12. Date of Statement: [illegible]

13. Name of Registrar: [illegible]  
14. Signature of Registrar: [illegible]  
15. Date of Registration: [illegible]  
16. Place of Registration: [illegible]

0417 CERTIFICATE OF DEATH

Reg. Dist. No.

00412

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN lb <u>1 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 Aigburth Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY- R- WPPERCO</u>				4. DATE OF DEATH Month Day Year <u>June 10 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 1-1859</u>	
9. AGE (In years last birthday) <u>101</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hick.</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph Nash</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Cole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Miss Mary Wpperco - Towson MD</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensative Cardio Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 12</u> , 19 <u>58</u> , to <u>Jan 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>60</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurence C. Post M.D.</u>				ADDRESS (Street, city or town, state) <u>6005 York Rd. Baltimore 12 MD</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-13-60</u>		<u>St Paul's</u>		<u>Uppero Baltoes MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw J Tipton</u>				ADDRESS <u>Hampstead MD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0418

## CERTIFICATE OF DEATH

00413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN IB <b>20 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>M.</b> Last <b>Vaughn</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>18,</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William E. Bensel</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Rapp</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elizabeth Bensel 2000 Mosby Ave.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>5 yrs.</b> <b>15 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 1957</b> to <b>Jan 18, 1960</b> , that I last saw the deceased alive on <b>Jan 11, 1960</b> , and that death occurred at <b>10:27 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Geo E Wells</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4100 Edmondson Ave, 1-19-60</b>	
PHYSICIAN'S NAME (Type) <b>George E. Wells</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-21-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J Howard Strong 3207 W. NORTH AVE,</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Frank</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00414

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHITE MARSH - Balto Rural</b>		c. LENGTH OF STAY IN 1b <b>9 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RANDOLPH Charles Voltmer</b>		4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 July 1879</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wood worker</b>	11. BIRTHPLACE (State or foreign country) <b>Longina N.Y.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Anthony Voltmer</b>	
14. MOTHER'S MAIDEN NAME <b>Adella Wilson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>422.1</b>		17. INFORMANT <b>Mabel Voltmer wife</b> Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke - Cerebral vascular Occlusion</b> DUE TO (b) <b>Atherosclerotic Cardio Vascular Disease</b> DUE TO (c) <b>unk.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John C. Hyle</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JOHN C. Hyle</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/18/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Crownhill Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Utica N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Jones</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>	
ADDRESS <b>Belair Rd., Balto., Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BACK ground Hist abt. Dr. Kulobony B. Baltimore Md.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*Signature of Medical Examiner*  
*W. H. H. H.*

*Signature of Medical Examiner*  
*W. H. H. H.*

*Signature of Medical Examiner*  
*W. H. H. H.*

*Signature of Medical Examiner*  
*W. H. H. H.*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **00415**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>60 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>---</b> Last <b>VYKOUKAL</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 13, 1919</b>
9. AGE (In years last birthday) <b>40</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES VYKOUKAL</b>	
14. MOTHER'S MAIDEN NAME <b>JOSEPHINE PAKIR</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>	
16. SOCIAL SECURITY NO. <b>WW-11</b>		17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>200.1</b> IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>1-1/2 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 12, 1959</b> to <b>January 11, 1960</b> , that I had no other cause of death, and that death occurred at <b>7:30 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO 18, MD. FT. HOWARD DIV. 1/12/60</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, BALTO 18, MD. FT. HOWARD DIV. 1/12/60</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-15-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCULEY FUNERAL HOME, 237 Patapsco Ave</b>		24a. REC'D BY REGISTRAR <b>JAN 14 60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEFENSE

WASHINGTON

WASHINGTON

WASHINGTON

10-10-60

10-10-60

120 WASHINGTON

VETERANS AND REENTRY BOARD

11-10-60

11-10-60

VIA MAIL

JOSEPH

10-10-60

10-10-60

10-10-60

10-10-60

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

10-10-60

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

0421

## CERTIFICATE OF DEATH

Reg. Dist. No.

00416

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>22 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>2303 Washington Boulevard</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>WARREN</b> Last			4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1921</b>		9. AGE (In years last birthday) yrs. <b>38</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	11. BIRTHPLACE (State or foreign country) <b>Wilmington, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.A.</b>
13. FATHER'S NAME <b>James E. Warren</b>			14. MOTHER'S MAIDEN NAME <b>Lula Tippet</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 11 212-18-0421</b>		INFORMANT Address <b>Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> <b>XXXX</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>PULMONARY EDEMA</b> DUE TO (c) RECENT					INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 29, 1959</b> to <b>January 20, 1960</b> , and that death occurred at <b>1:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. 18, MD. FT. HOWARD DIV. 1/21/60</b> ACTUAL SIGNATURE <b>W. J. PIJANOWSKI</b> M.D. PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>					
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>25 JAN 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore</b>	
22d. LOCATION (City, town, or county) (State) <b>Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Towlson, 2359 Washington Blvd, Balto. Md.</b>			24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0422

## CERTIFICATE OF DEATH

00417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>			c. LENGTH OF STAY IN 1b <b>20 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>York Rd.</b>				d. STREET ADDRESS <b>York Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Egerton</b> Last <b>Watkins</b>				4. DATE OF DEATH Month <b>1-28-60</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-10-1910</b>		9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months <b>49</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>gasoline station</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Watkins</b>				14. MOTHER'S MAIDEN NAME <b>Florence Dickinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-05-4615</b>		INFORMANT <b>Mary K. Watkins</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen. Arteriosclerosis</b> DUE TO (c) <b>Chr. Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-28-60</b> to <b>1-28-60</b> that I last saw the deceased alive on <b>1-28-60</b> and that death occurred at <b>10:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>Feb 1 '60</b>							
ACTUAL SIGNATURE <b>Robert H. Silver</b>		M.D. <b>3105 N. Charles St.</b>					
PHYSICIAN'S NAME (Type) <b>R.H. Silver</b>		<b>Baltimore, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				ADDRESS <b>Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Baltimore

Maryland

Baltimore

Cockeysville

30 yrs.

Cockeysville

York Md.

York Md.

1-22-60

Howard E. Barton

MD

11-10-1910

male white

U.S.A.

Gasoline station New Jersey

owner operator

Flora E. Barton

Howard E. Barton

above

215-05-4615 Mary E. Barton

no

the nine level and Howard E. Barton

the nine level and Howard E. Barton

Baltimore, Maryland

London Park

215-05-4615

Proctor Funeral Home, Towson 4, Md.

1 X  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0423

CERTIFICATE OF DEATH

Reg. Dist. No.

00418

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>41 Days</u>		d. STREET ADDRESS <u>4742 Wrenwood Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BASIL</u> Middle <u>M.</u> Last <u>WEBSTER</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 21, 1911</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Arsenal</u>	
11. BIRTHPLACE (State or foreign country) <u>Atlantic City, N. Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harry Webster</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Shorter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>150-07-5009</u>	
17. INFORMANT <u>Clin. Rec., VAH, Baltimore 18, Md. Ft. Howard Division</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>  </u> <u>  </u> <u>19</u> Hour <u>  </u> o. m. <u>  </u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 21, 1959</u> to <u>January 4, 1960</u> , that he was the deceased alive on <u>  </u> and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, BALTO. 18, MD. FT. HOWARD DIV.</u> DATE SIGNED <u>1/5/60</u>			
ACTUAL SIGNATURE <u>John W. Crawford</u>		M.D. <u>VAH, BALTO. 18, MD. FT. HOWARD DIV.</u> DATE <u>1/5/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN W. CRAWFORD, M.D.</u>		VAH, BALTO. 18, MD. FT. HOWARD DIVISION <u>1/5/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-8-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Kelson</u> ADDRESS <u>1348 N. Calhoun St./Balto. Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 6 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

County of \_\_\_\_\_  
City of \_\_\_\_\_  
Town of \_\_\_\_\_  
Village of \_\_\_\_\_  
Post Office of \_\_\_\_\_

Decedent's Name \_\_\_\_\_  
Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Race \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Occupation \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Date of Death \_\_\_\_\_

Physician's Name \_\_\_\_\_  
Physician's Address \_\_\_\_\_  
Physician's Signature \_\_\_\_\_  
Medical Examiner's Name \_\_\_\_\_  
Medical Examiner's Address \_\_\_\_\_  
Medical Examiner's Signature \_\_\_\_\_

Funeral Home Name \_\_\_\_\_  
Funeral Home Address \_\_\_\_\_  
Funeral Home Signature \_\_\_\_\_  
Burial Place Name \_\_\_\_\_  
Burial Place Address \_\_\_\_\_  
Burial Place Signature \_\_\_\_\_

Registrar's Name \_\_\_\_\_  
Registrar's Address \_\_\_\_\_  
Registrar's Signature \_\_\_\_\_  
Date of Registration \_\_\_\_\_  
Place of Registration \_\_\_\_\_

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
090  
1  
0  
1  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND  
0424 CERTIFICATE OF DEATH

00419

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> <b>MAYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MAYLAND</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>3 YEARS</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3Y01-4</b>				d. STREET ADDRESS <b>606 N. HILTON ST.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>GOOTEE</b> Last <b>WEIGLE</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-22-1880</b>	
9. AGE (In years lost birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min.		IF UNDER 24 HRS. Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U. S.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>JAMES H. HUBBARD</b>				14. MOTHER'S MAIDEN NAME <b>GRACE GOOTEE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>212-07-0188-D</b>		17. INFORMANT <b>Frank R. Smith Jr. - Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Arterio Sclerotic Cardio</b> DUE TO (b) <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) <b>3 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore, Maryland</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-9-56</b> to <b>1-18</b> 19 <b>60</b> , that (I) (we) lost the deceased alive on <b>1-18</b> 19 <b>60</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter T. Kees</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>				22d. ADDRESS <b>COCKEYSVILLE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Avenue</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Kenna</b>			

043 - CERTIFICATE OF DEATH

DATE OF DEATH: 1943-11-11

TIME OF DEATH: 10:30 AM

PLACE OF DEATH: 1000 1st Street, N.W., Washington, D.C.

NAME OF DECEASED: JAMES H. GUTTER

DATE OF BIRTH: 1911-11-11

PLACE OF BIRTH: 1000 1st Street, N.W., Washington, D.C.

CAUSE OF DEATH: 1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.

1000 1st Street, N.W., Washington, D.C.



VS A15 (4)  
15M 9/55

# CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text, illegible]		2. SEX [Faint text, illegible]	
3. AGE [Faint text, illegible]		4. DATE OF BIRTH [Faint text, illegible]	
5. PLACE OF BIRTH [Faint text, illegible]		6. DATE OF DEATH [Faint text, illegible]	
7. TIME OF DEATH [Faint text, illegible]		8. PLACE OF DEATH [Faint text, illegible]	
9. CAUSE OF DEATH [Faint text, illegible]		10. MANNER OF DEATH [Faint text, illegible]	
11. SIGNATURE OF DECEASED [Faint text, illegible]		12. SIGNATURE OF WITNESSES [Faint text, illegible]	
13. SIGNATURE OF PHYSICIAN [Faint text, illegible]		14. SIGNATURE OF CORONER [Faint text, illegible]	
15. SIGNATURE OF JUDGE [Faint text, illegible]		16. SIGNATURE OF CLERK [Faint text, illegible]	

This certificate is valid only when filed in the office of the Registrar of Births and Deaths, and is not valid if used for any other purpose.

This certificate is valid only when filed in the office of the Registrar of Births and Deaths, and is not valid if used for any other purpose.

0426

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8114 Kirkwall Ct.</u>				d. STREET ADDRESS <u>8114 Kirkwall Ct.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary L. Welker</u>				4. DATE OF DEATH Month Day Year <u>January 6 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1917</u>	
9. AGE (In years, day, month, year) <u>42</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto.Co.Dept.Ed.</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John McPherson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>278-14-3710</u>			
17. INFORMANT <u>Francis W. Welker</u>				Address <u>8114 Kirkwall Ct.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>170x</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u>				20g. (County) <u>Baltimore</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>1/1</u> , 19 <u>56</u> , to <u>1/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>59</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Franklin E. Lohie</u>				DATE SIGNED <u>2929 N. Charles St</u>			
PHYSICIAN'S NAME (Type) <u>Franklin E. Lohie</u>				ADDRESS <u>Baltimore 18, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Lafayette</u>		22d. LOCATION (City, town, or county) (State) <u>Newcomerstown Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson Inc. 1050 York Rd. #4</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0427

Item 1c Film G255 1-27-60 et

CERTIFICATE OF DEATH

00422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>WENTZ</u> Last <u>WENTZ</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-21-88</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u>		11. IF UNDER 24 HRS. Hours <u>71</u> Min. <u>71</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Bkkeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>			
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Wentz</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Gruender</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>MRS. MAMIE SMITH</u>				Address <u>4905 Denmore Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 18, 1960</u> to <u>Jan. 20, 1960</u> that I last saw the deceased alive on <u>Jan. 20, 1960</u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>1-20-60</u>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/23/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Vernon Lemmon</u>				24a. REC'D BY REGISTRAR <u>JAN 21 '60</u>			
ADDRESS <u>4611 Park Heights, Balto. Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1903.

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 1, 1903.

JOHN W. WALKER,  
COMMISSIONER OF THE LAND OFFICE.

ALBANY:  
JANUARY 1, 1903.

10

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.  
1903.

THE STATE OF NEW YORK: J. B. LIPPINCOTT & CO., PRINTERS.  
1903.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 8 Film G254 1-20-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

00423

0422

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Allender Road</u>				e. STREET ADDRESS <u>Allender Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>White</u> Last <u>White</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5 1883</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>W Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob White</u>				14. MOTHER'S MAIDEN NAME <u>Deleah Stump</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Austin White</u> Address <u>17 N Chester St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>4</u> p.m. Month <u>7</u> Day <u>1</u> Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>1-13</u> , 19 <u>57</u> , to <u>1-12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>60</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Belt Air, Md</u>		DATE SIGNED <u>1-13-60</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal Jan 14/60</u>	22b. DATE THEREOF <u>1/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olive</u>	22d. LOCATION (City, town, or county) <u>Rowlesburg W Va</u>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Road Home 4210 Bel Air Rd</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. PLACE OF DEATH <i>Home</i>	
3. SEX <i>Male</i>		4. AGE <i>65</i>	
5. DATE OF DEATH <i>Jan 15 1950</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>	
9. PLACE OF BIRTH <i>Baltimore, Md</i>		10. DATE OF BIRTH <i>Jan 1 1885</i>	
11. OCCUPATION <i>Teacher</i>		12. MARITAL STATUS <i>Married</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF PHYSICIAN <i>John Doe</i>		18. SIGNATURE OF CORONER <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JUDGE <i>John Doe</i>	

4

1

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY FALSIFICATION OR MISUSE OF THIS RECORD IS A VIOLATION OF THE LAW AND IS SUBJECT TO PROSECUTION.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00424

## 0428 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr7mth26dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>James</b> Last <b>Wilson</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maintenance man</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward James WILSON</b>		14. MOTHER'S MAIDEN NAME <b>Theresa ? CARNEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Army</b>		16. SOCIAL SECURITY NO. <b>218-07-5377</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 450.0 DUE TO (b) <b>Uremia</b> DUE TO (c) <b>generalized Arteriosclerosis</b> lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>1 month</b> <b>long standing</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 22</b> , 19 <b>58</b> , to <b>1-11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-10</b> , 19 <b>60</b> , and that death occurred at <b>2:40</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>1-11-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/13/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Truman Schwalb</b>		24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>	
ADDRESS <b>3512 Fed. Ave. -29-</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1921

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of death: *Jan 15 1921*  
5. Place of death: *New York City*  
6. Cause of death: *Heart Disease*  
7. Signature of physician: *Dr. J. Smith*  
8. Signature of registrar: *John Doe*  
9. Date of registration: *Jan 16 1921*

0430

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Owings Mills, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>10827 Reisterstown Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura Jane Wimsett</u>				4. DATE OF DEATH Month Day Year <u>January 24, 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Stevenson, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Milton Hood</u>				14. MOTHER'S MAIDEN NAME <u>Alethia Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		INFORMANT <u>Mrs. Laura A. Redifer, 10827 Reisterstown Rd Owings Mills, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Pneumonia - Hypostatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Myocarditis - decompensated</u> DUE TO (c) <u>Washed general arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 yrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1-60</u> to <u>1-24-60</u> , that I last saw the deceased alive on <u>1-24-60</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G. Saffell</u>		M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown Md</u>		DATE SIGNED <u>1-26-60</u>	
PHYSICIAN'S NAME (Type) <u>James G. Saffell M.D. Reisterstown Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Hand</u>		ADDRESS <u>Pikesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE ARABIAN STATES: PART OF HISTORY - PART OF THE FUTURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00426

0431

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1y1mth23dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Winkler</u> Last <u>Winkler</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>8,</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7, 1875</u>	
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>04</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>		11. IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
13. FATHER'S NAME <u>John Winkler</u>				14. MOTHER'S MAIDEN NAME <u>Malina ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>			
INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				Address <u>SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Arterioscler. Cardio Vasc. Disease</u> DUE TO (c) <u>Arteriosclerosis gener. severe</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 25</u> , 19 <u>58</u> to <u>1-8-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-8</u> , 19 <u>60</u> , and that death occurred at <u>7 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Stella Wachler</u>				M.D. <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachler</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC. 715 Light St. -30</u>				24a. REC'D BY REGISTRAR <u>JAN 12 1960</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>			

CERTIFICATE OF DEATH

0202

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1003-02

U N 30 AM

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00427

0432  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Boring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dover Rd.</u>		d. STREET ADDRESS <u>Dover Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First Middle Last <u>Wise</u>		4. DATE OF DEATH <u>Jan. 19, 1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Channell</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Harry E. Wise</u> Address <u>Reisterstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>260 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 1955</u> to <u>January 19, 1960</u> , that I last saw the deceased alive on <u>January 18, 1960</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u> DATE SIGNED <u>January 19, 1960</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 23, 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Finksburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline &amp; Sons</u> ADDRESS <u>Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 21 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>G. L. S. King</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. OCCUPATION		11. EDUCATION		12. MARITAL STATUS	
13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA	
16. PREVIOUS DRUGS		17. PREVIOUS ALCOHOL		18. PREVIOUS TOBACCO	
19. PREVIOUS RADIATION		20. PREVIOUS CHEMOTHERAPY		21. PREVIOUS TRANSFUSION	
22. PREVIOUS ORGANS		23. PREVIOUS TISSUES		24. PREVIOUS CELLS	
25. PREVIOUS BLOOD		26. PREVIOUS URINE		27. PREVIOUS SWEAT	
28. PREVIOUS SALIVA		29. PREVIOUS TEARS		30. PREVIOUS SPERM	
31. PREVIOUS OVUM		32. PREVIOUS EMBRYO		33. PREVIOUS FETUS	
34. PREVIOUS INFANT		35. PREVIOUS CHILD		36. PREVIOUS ADULT	
37. PREVIOUS ELDERLY		38. PREVIOUS DECEASED		39. PREVIOUS BURIED	
40. PREVIOUS CREMATED		41. PREVIOUS INTERMENT		42. PREVIOUS MONUMENT	
43. PREVIOUS GRAVE		44. PREVIOUS CRYPT		45. PREVIOUS CHapel	
46. PREVIOUS CHURCH		47. PREVIOUS SYNAGOGUE		48. PREVIOUS MOSQUE	
49. PREVIOUS TEMPLE		50. PREVIOUS MANSION		51. PREVIOUS HOUSE	
52. PREVIOUS APARTMENT		53. PREVIOUS HOTEL		54. PREVIOUS INN	
55. PREVIOUS CAFE		56. PREVIOUS RESTAURANT		57. PREVIOUS BAR	
58. PREVIOUS CLUB		59. PREVIOUS GYM		60. PREVIOUS PARK	
61. PREVIOUS GARDEN		62. PREVIOUS LAWN		63. PREVIOUS DRIVE	
64. PREVIOUS ROAD		65. PREVIOUS HIGHWAY		66. PREVIOUS BRIDGE	
67. PREVIOUS TUNNEL		68. PREVIOUS TOWER		69. PREVIOUS SPHERE	
70. PREVIOUS CUBE		71. PREVIOUS PYRAMID		72. PREVIOUS CONE	
73. PREVIOUS CYLINDER		74. PREVIOUS RECTANGLE		75. PREVIOUS TRIANGLE	
76. PREVIOUS SQUARE		77. PREVIOUS DIAMOND		78. PREVIOUS STAR	
79. PREVIOUS HEART		80. PREVIOUS CROSS		81. PREVIOUS PLUS	
82. PREVIOUS X		83. PREVIOUS DOT		84. PREVIOUS LINE	
85. PREVIOUS CURVE		86. PREVIOUS ARC		87. PREVIOUS SEMI	
88. PREVIOUS QUARTER		89. PREVIOUS HALF		90. PREVIOUS WHOLE	
91. PREVIOUS PART		92. PREVIOUS PIECE		93. PREVIOUS BIT	
94. PREVIOUS SHARD		95. PREVIOUS CHIP		96. PREVIOUS FLAKE	
97. PREVIOUS CRACK		98. PREVIOUS FISSURE		99. PREVIOUS GASH	
100. PREVIOUS LACERATION		101. PREVIOUS WOUND		102. PREVIOUS SCALD	
103. PREVIOUS BURN		104. PREVIOUS FROST		105. PREVIOUS SUN	
106. PREVIOUS RAIN		107. PREVIOUS SNOW		108. PREVIOUS ICE	
109. PREVIOUS HAIL		110. PREVIOUS WIND		111. PREVIOUS FOG	
112. PREVIOUS MIST		113. PREVIOUS CLOUD		114. PREVIOUS RAIN	
115. PREVIOUS SNOW		116. PREVIOUS ICE		117. PREVIOUS HAIL	
118. PREVIOUS WIND		119. PREVIOUS FOG		120. PREVIOUS MIST	
121. PREVIOUS CLOUD		122. PREVIOUS RAIN		123. PREVIOUS SNOW	
124. PREVIOUS ICE		125. PREVIOUS HAIL		126. PREVIOUS WIND	
127. PREVIOUS FOG		128. PREVIOUS MIST		129. PREVIOUS CLOUD	
130. PREVIOUS RAIN		131. PREVIOUS SNOW		132. PREVIOUS ICE	
133. PREVIOUS HAIL		134. PREVIOUS WIND		135. PREVIOUS FOG	
136. PREVIOUS MIST		137. PREVIOUS CLOUD		138. PREVIOUS RAIN	
139. PREVIOUS SNOW		140. PREVIOUS ICE		141. PREVIOUS HAIL	
142. PREVIOUS WIND		143. PREVIOUS FOG		144. PREVIOUS MIST	
145. PREVIOUS CLOUD		146. PREVIOUS RAIN		147. PREVIOUS SNOW	
148. PREVIOUS ICE		149. PREVIOUS HAIL		150. PREVIOUS WIND	
151. PREVIOUS FOG		152. PREVIOUS MIST		153. PREVIOUS CLOUD	
154. PREVIOUS RAIN		155. PREVIOUS SNOW		156. PREVIOUS ICE	
157. PREVIOUS HAIL		158. PREVIOUS WIND		159. PREVIOUS FOG	
160. PREVIOUS MIST		161. PREVIOUS CLOUD		162. PREVIOUS RAIN	
163. PREVIOUS SNOW		164. PREVIOUS ICE		165. PREVIOUS HAIL	
166. PREVIOUS WIND		167. PREVIOUS FOG		168. PREVIOUS MIST	
169. PREVIOUS CLOUD		170. PREVIOUS RAIN		171. PREVIOUS SNOW	
172. PREVIOUS ICE		173. PREVIOUS HAIL		174. PREVIOUS WIND	
175. PREVIOUS FOG		176. PREVIOUS MIST		177. PREVIOUS CLOUD	
178. PREVIOUS RAIN		179. PREVIOUS SNOW		180. PREVIOUS ICE	
181. PREVIOUS HAIL		182. PREVIOUS WIND		183. PREVIOUS FOG	
184. PREVIOUS MIST		185. PREVIOUS CLOUD		186. PREVIOUS RAIN	
187. PREVIOUS SNOW		188. PREVIOUS ICE		189. PREVIOUS HAIL	
190. PREVIOUS WIND		191. PREVIOUS FOG		192. PREVIOUS MIST	
193. PREVIOUS CLOUD		194. PREVIOUS RAIN		195. PREVIOUS SNOW	
196. PREVIOUS ICE		197. PREVIOUS HAIL		198. PREVIOUS WIND	
199. PREVIOUS FOG		200. PREVIOUS MIST		201. PREVIOUS CLOUD	
202. PREVIOUS RAIN		203. PREVIOUS SNOW		204. PREVIOUS ICE	
205. PREVIOUS HAIL		206. PREVIOUS WIND		207. PREVIOUS FOG	
208. PREVIOUS MIST		209. PREVIOUS CLOUD		210. PREVIOUS RAIN	
211. PREVIOUS SNOW		212. PREVIOUS ICE		213. PREVIOUS HAIL	
214. PREVIOUS WIND		215. PREVIOUS FOG		216. PREVIOUS MIST	
217. PREVIOUS CLOUD		218. PREVIOUS RAIN		219. PREVIOUS SNOW	
220. PREVIOUS ICE		221. PREVIOUS HAIL		222. PREVIOUS WIND	
223. PREVIOUS FOG		224. PREVIOUS MIST		225. PREVIOUS CLOUD	
226. PREVIOUS RAIN		227. PREVIOUS SNOW		228. PREVIOUS ICE	
229. PREVIOUS HAIL		230. PREVIOUS WIND		231. PREVIOUS FOG	
232. PREVIOUS MIST		233. PREVIOUS CLOUD		234. PREVIOUS RAIN	
235. PREVIOUS SNOW		236. PREVIOUS ICE		237. PREVIOUS HAIL	
238. PREVIOUS WIND		239. PREVIOUS FOG		240. PREVIOUS MIST	
241. PREVIOUS CLOUD		242. PREVIOUS RAIN		243. PREVIOUS SNOW	
244. PREVIOUS ICE		245. PREVIOUS HAIL		246. PREVIOUS WIND	
247. PREVIOUS FOG		248. PREVIOUS MIST		249. PREVIOUS CLOUD	
250. PREVIOUS RAIN		251. PREVIOUS SNOW		252. PREVIOUS ICE	
253. PREVIOUS HAIL		254. PREVIOUS WIND		255. PREVIOUS FOG	
256. PREVIOUS MIST		257. PREVIOUS CLOUD		258. PREVIOUS RAIN	
259. PREVIOUS SNOW		260. PREVIOUS ICE		261. PREVIOUS HAIL	
262. PREVIOUS WIND		263. PREVIOUS FOG		264. PREVIOUS MIST	
265. PREVIOUS CLOUD		266. PREVIOUS RAIN		267. PREVIOUS SNOW	
268. PREVIOUS ICE		269. PREVIOUS HAIL		270. PREVIOUS WIND	
271. PREVIOUS FOG		272. PREVIOUS MIST		273. PREVIOUS CLOUD	
274. PREVIOUS RAIN		275. PREVIOUS SNOW		276. PREVIOUS ICE	
277. PREVIOUS HAIL		278. PREVIOUS WIND		279. PREVIOUS FOG	
280. PREVIOUS MIST		281. PREVIOUS CLOUD		282. PREVIOUS RAIN	
283. PREVIOUS SNOW		284. PREVIOUS ICE		285. PREVIOUS HAIL	
286. PREVIOUS WIND		287. PREVIOUS FOG		288. PREVIOUS MIST	
289. PREVIOUS CLOUD		290. PREVIOUS RAIN		291. PREVIOUS SNOW	
292. PREVIOUS ICE		293. PREVIOUS HAIL		294. PREVIOUS WIND	
295. PREVIOUS FOG		296. PREVIOUS MIST		297. PREVIOUS CLOUD	
298. PREVIOUS RAIN		299. PREVIOUS SNOW		300. PREVIOUS ICE	



1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF DEATH  
5. TIME OF DEATH  
6. PLACE OF DEATH  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. PLACE OF BIRTH  
10. OCCUPATION  
11. EDUCATION  
12. MARITAL STATUS  
13. PREVIOUS ILLNESS  
14. PREVIOUS SURGERY  
15. PREVIOUS TRAUMA  
16. PREVIOUS DRUGS  
17. PREVIOUS ALCOHOL  
18. PREVIOUS TOBACCO  
19. PREVIOUS RADIATION  
20. PREVIOUS CHEMOTHERAPY  
21. PREVIOUS TRANSFUSION  
22. PREVIOUS ORGANS  
23. PREVIOUS TISSUES  
24. PREVIOUS CELLS  
25. PREVIOUS BLOOD  
26. PREVIOUS URINE  
27. PREVIOUS SWEAT  
28. PREVIOUS SALIVA  
29. PREVIOUS TEARS  
30. PREVIOUS SPERM  
31. PREVIOUS OVUM  
32. PREVIOUS EMBRYO  
33. PREVIOUS FETUS  
34. PREVIOUS INFANT  
35. PREVIOUS CHILD  
36. PREVIOUS ADULT  
37. PREVIOUS ELDERLY  
38. PREVIOUS DECEASED  
39. PREVIOUS BURIED  
40. PREVIOUS CREMATED  
41. PREVIOUS INTERMENT  
42. PREVIOUS MONUMENT  
43. PREVIOUS GRAVE  
44. PREVIOUS CRYPT  
45. PREVIOUS CHapel  
46. PREVIOUS CHURCH  
47. PREVIOUS SYNAGOGUE  
48. PREVIOUS MOSQUE  
49. PREVIOUS TEMPLE  
50. PREVIOUS MANSION  
51. PREVIOUS HOUSE  
52. PREVIOUS APARTMENT  
53. PREVIOUS HOTEL  
54. PREVIOUS INN  
55. PREVIOUS CAFE  
56. PREVIOUS RESTAURANT  
57. PREVIOUS BAR  
58. PREVIOUS CLUB  
59. PREVIOUS GYM  
60. PREVIOUS PARK  
61. PREVIOUS GARDEN  
62. PREVIOUS LAWN  
63. PREVIOUS DRIVE  
64. PREVIOUS ROAD  
65. PREVIOUS HIGHWAY  
66. PREVIOUS BRIDGE  
67. PREVIOUS TUNNEL  
68. PREVIOUS TOWER  
69. PREVIOUS SPHERE  
70. PREVIOUS CUBE  
71. PREVIOUS PYRAMID  
72. PREVIOUS CONE  
73. PREVIOUS CYLINDER  
74. PREVIOUS RECTANGLE  
75. PREVIOUS TRIANGLE  
76. PREVIOUS SQUARE  
77. PREVIOUS DIAMOND  
78. PREVIOUS STAR  
79. PREVIOUS HEART  
80. PREVIOUS CROSS  
81. PREVIOUS PLUS  
82. PREVIOUS X  
83. PREVIOUS DOT  
84. PREVIOUS LINE  
85. PREVIOUS CURVE  
86. PREVIOUS ARC  
87. PREVIOUS SEMI  
88. PREVIOUS QUARTER  
89. PREVIOUS HALF  
90. PREVIOUS WHOLE  
91. PREVIOUS PART  
92. PREVIOUS PIECE  
93. PREVIOUS BIT  
94. PREVIOUS SHARD  
95. PREVIOUS CHIP  
96. PREVIOUS FLAKE  
97. PREVIOUS CRACK  
98. PREVIOUS FISSURE  
99. PREVIOUS GASH  
100. PREVIOUS LACERATION  
101. PREVIOUS WOUND  
102. PREVIOUS SCALD  
103. PREVIOUS BURN  
104. PREVIOUS FROST  
105. PREVIOUS SUN  
106. PREVIOUS RAIN  
107. PREVIOUS SNOW  
108. PREVIOUS ICE  
109. PREVIOUS HAIL  
110. PREVIOUS WIND  
111. PREVIOUS FOG  
112. PREVIOUS MIST  
113. PREVIOUS CLOUD  
114. PREVIOUS RAIN  
115. PREVIOUS SNOW  
116. PREVIOUS ICE  
117. PREVIOUS HAIL  
118. PREVIOUS WIND  
119. PREVIOUS FOG  
120. PREVIOUS MIST  
121. PREVIOUS CLOUD  
122. PREVIOUS RAIN  
123. PREVIOUS SNOW  
124. PREVIOUS ICE  
125. PREVIOUS HAIL  
126. PREVIOUS WIND  
127. PREVIOUS FOG  
128. PREVIOUS MIST  
129. PREVIOUS CLOUD  
130. PREVIOUS RAIN  
131. PREVIOUS SNOW  
132. PREVIOUS ICE  
133. PREVIOUS HAIL  
134. PREVIOUS WIND  
135. PREVIOUS FOG  
136. PREVIOUS MIST  
137. PREVIOUS CLOUD  
138. PREVIOUS RAIN  
139. PREVIOUS SNOW  
140. PREVIOUS ICE  
141. PREVIOUS HAIL  
142. PREVIOUS WIND  
143. PREVIOUS FOG  
144. PREVIOUS MIST  
145. PREVIOUS CLOUD  
146. PREVIOUS RAIN  
147. PREVIOUS SNOW  
148. PREVIOUS ICE  
149. PREVIOUS HAIL  
150. PREVIOUS WIND  
151. PREVIOUS FOG  
152. PREVIOUS MIST  
153. PREVIOUS CLOUD  
154. PREVIOUS RAIN  
155. PREVIOUS SNOW  
156. PREVIOUS ICE  
157. PREVIOUS HAIL  
158. PREVIOUS WIND  
159. PREVIOUS FOG  
160. PREVIOUS MIST  
161. PREVIOUS CLOUD  
162. PREVIOUS RAIN  
163. PREVIOUS SNOW  
164. PREVIOUS ICE  
165. PREVIOUS HAIL  
166. PREVIOUS WIND  
167. PREVIOUS FOG  
168. PREVIOUS MIST  
169. PREVIOUS CLOUD  
170. PREVIOUS RAIN  
171. PREVIOUS SNOW  
172. PREVIOUS ICE  
173. PREVIOUS HAIL  
174. PREVIOUS WIND  
175. PREVIOUS FOG  
176. PREVIOUS MIST  
177. PREVIOUS CLOUD  
178. PREVIOUS RAIN  
179. PREVIOUS SNOW  
180. PREVIOUS ICE  
181. PREVIOUS HAIL  
182. PREVIOUS WIND  
183. PREVIOUS FOG  
184. PREVIOUS MIST  
185. PREVIOUS CLOUD  
186. PREVIOUS RAIN  
187. PREVIOUS SNOW  
188. PREVIOUS ICE  
189. PREVIOUS HAIL  
190. PREVIOUS WIND  
191. PREVIOUS FOG  
192. PREVIOUS MIST  
193. PREVIOUS CLOUD  
194. PREVIOUS RAIN  
195. PREVIOUS SNOW  
196. PREVIOUS ICE  
197. PREVIOUS HAIL  
198. PREVIOUS WIND  
199. PREVIOUS FOG  
200. PREVIOUS MIST  
201. PREVIOUS CLOUD  
202. PREVIOUS RAIN  
203. PREVIOUS SNOW  
204. PREVIOUS ICE  
205. PREVIOUS HAIL  
206. PREVIOUS WIND  
207. PREVIOUS FOG  
208. PREVIOUS MIST  
209. PREVIOUS CLOUD  
210. PREVIOUS RAIN  
211. PREVIOUS SNOW  
212. PREVIOUS ICE  
213. PREVIOUS HAIL  
214. PREVIOUS WIND  
215. PREVIOUS FOG  
216. PREVIOUS MIST  
217. PREVIOUS CLOUD  
218. PREVIOUS RAIN  
219. PREVIOUS SNOW  
220. PREVIOUS ICE  
221. PREVIOUS HAIL  
222. PREVIOUS WIND  
223. PREVIOUS FOG  
224. PREVIOUS MIST  
225. PREVIOUS CLOUD  
226. PREVIOUS RAIN  
227. PREVIOUS SNOW  
228. PREVIOUS ICE  
229. PREVIOUS HAIL  
230. PREVIOUS WIND  
231. PREVIOUS FOG  
232. PREVIOUS MIST  
233. PREVIOUS CLOUD  
234. PREVIOUS RAIN  
235. PREVIOUS SNOW  
236. PREVIOUS ICE  
237. PREVIOUS HAIL  
238. PREVIOUS WIND  
239. PREVIOUS FOG  
240. PREVIOUS MIST  
241. PREVIOUS CLOUD  
242. PREVIOUS RAIN  
243. PREVIOUS SNOW  
244. PREVIOUS ICE  
245. PREVIOUS HAIL  
246. PREVIOUS WIND  
247. PREVIOUS FOG  
248. PREVIOUS MIST  
249. PREVIOUS CLOUD  
250. PREVIOUS RAIN  
251. PREVIOUS SNOW  
252. PREVIOUS ICE  
253. PREVIOUS HAIL  
254. PREVIOUS WIND  
255. PREVIOUS FOG  
256. PREVIOUS MIST  
257. PREVIOUS CLOUD  
258. PREVIOUS RAIN  
259. PREVIOUS SNOW  
260. PREVIOUS ICE  
261. PREVIOUS HAIL  
262. PREVIOUS WIND  
263. PREVIOUS FOG  
264. PREVIOUS MIST  
265. PREVIOUS CLOUD  
266. PREVIOUS RAIN  
267. PREVIOUS SNOW  
268. PREVIOUS ICE  
269. PREVIOUS HAIL  
270. PREVIOUS WIND  
271. PREVIOUS FOG  
272. PREVIOUS MIST  
273. PREVIOUS CLOUD  
274. PREVIOUS RAIN  
275. PREVIOUS SNOW  
276. PREVIOUS ICE  
277. PREVIOUS HAIL  
278. PREVIOUS WIND  
279. PREVIOUS FOG  
280. PREVIOUS MIST  
281. PREVIOUS CLOUD  
282. PREVIOUS RAIN  
283. PREVIOUS SNOW  
284. PREVIOUS ICE  
285. PREVIOUS HAIL  
286. PREVIOUS WIND  
287. PREVIOUS FOG  
288. PREVIOUS MIST  
289. PREVIOUS CLOUD  
290. PREVIOUS RAIN  
291. PREVIOUS SNOW  
292. PREVIOUS ICE  
293. PREVIOUS HAIL  
294. PREVIOUS WIND  
295. PREVIOUS FOG  
296. PREVIOUS MIST  
297. PREVIOUS CLOUD  
298. PREVIOUS RAIN  
299. PREVIOUS SNOW  
300. PREVIOUS ICE

## 0423 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b <b>4 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8617 OAKLEIGH ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE P. WITTS SR.</b>		4. DATE OF DEATH Month Day Year <b>JAN. 13, 1960 19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 21, 1894</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HENRY WITTS</b>	
14. MOTHER'S MAIDEN NAME <b>EMMA STERNS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>218 10 2940</b>		INFORMANT Address <b>MR. CHARLES WITTS 8617 OAKLEIGH ROAD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Anteroselective C-V disease</b> DUE TO (b) <b>Chronic Glomerular Nephritis</b> DUE TO (c) <b>Chronic Bronchitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b> <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchitis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 3, 1954</b> to <b>Jan. 13, 1960</b> that I last saw the deceased alive on <b>Jan. 10, 1960</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. H. Grenzer</b> M.D.		ADDRESS (Street, city or town, state) <b>1520 E. 33rd St. Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>WM. H. GRENZER</b>		DATE SIGNED <b>1.14.60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Jan. 18, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL PARK BALTIMORE MARYLAND</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

STATE OF OHIO  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CITY OF CLEVELAND  
OFFICE OF THE REGISTRAR  
CERIFICATE OF DEATH

1911

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0434

## CERTIFICATE OF DEATH

00429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>45 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 Waldron Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>M.</b> Last <b>Wladika</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1900</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Mallonee</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude A. Tarbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Michael Wladika</b>		Address <b>15 Waldron Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1954</b> to <b>Jan. 18, 1960</b> , that I last saw the deceased alive on <b>January 18, 1960</b> , and that death occurred at <b>5:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Reistwn Rd. &amp; Walker Ave.</b> DATE SIGNED <b>1/24/60</b>			
ACTUAL SIGNATURE <b>James A. Miller</b>		M.D. <b>Reistwn Rd. &amp; Walker Ave.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James A. Miller</b>		<b>Reistwn. Rd. &amp; Walker Ave. Pikesville 8</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/21/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Spring Byers</b>		ADDRESS <b>8728 Liberty Road</b>	
24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

•

•

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0435

CERTIFICATE OF DEATH

Reg. Dist. No.

00430

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3401-4</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>137 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Also: WOOD and WOODWARD</b> Middle Last <b>WALLACE WOODARD</b>		4. DATE OF DEATH Month Day Year <b>January 8 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1895</b>
9. AGE (In years lost birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Candy Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Candy Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Stafford, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Woodard</b>		14. MOTHER'S MAIDEN NAME <b>Kate Woodard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>719-09-1285</b>	
17. INFORMANT <b>Clin, Records VA Hospital Balto Md, Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG</b> DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 24</b> , 19 <b>59</b> , to <b>January 8</b> , 19 <b>60</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles Allen, M.D. VAH Balto., Md., Ft. Howard Div. 1/9/60</b>			
ACTUAL SIGNATURE <b>Charles Allen, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>			

DECLARATION OF DEATH

Deceased

Witness

I, the undersigned, being a competent person, do hereby certify that

the above-named person is dead, and that the death occurred on

the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_

\_\_\_\_\_ State of \_\_\_\_\_

\_\_\_\_\_ County of \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0436

CERTIFICATE OF DEATH

Reg. Dist. No.

00431

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN Tb <b>9mth29dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Margaret</b> Last <b>Wooden</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1881</b>		9. AGE (In years lost birthday) <b>78</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife (Nurse- Ret'd)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>William Weyrauch</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Rehbein</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>422.1</b> DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b>		(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>Jan. 19</b> , 19 <b>60</b> , to <b>Jan. 20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 20</b> , 19 <b>60</b> , and that death occurred at <b>2:00a</b> m, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 1-20-60</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-22-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Ciribus S. Kraus</b>	

DOI: 10.1002/for



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0228 CERTIFICATE OF DEATH

00432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>818 S. 50th St.</b>		d. STREET ADDRESS <b>818 S. 50th St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>THERESA</b> Last <b>WUNSCH.</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1960.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1884</b>
9. AGE (In years last birthday) yrs. <b>75</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home.</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jeremiah Hartnett</b>		14. MOTHER'S MAIDEN NAME <b>Honora Sullivan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>-----</b>	
17. INFORMANT <b>John J. Wunsch</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X Diabetes Mellitus (Coma)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerosis</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1950</b> <b>1952</b> <b>1945</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>45</b> , to <b>Jan 9</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 9</b> , 19 <b>60</b> , and that death occurred at <b>4:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>MORRIS G. Jacobs</b> M.D.		ADDRESS (Street, city or town, state) <b>1010 NORTH Pkwy</b>	
PHYSICIAN'S NAME (Type) <b>MORRIS A. Jacobs</b>		DATE SIGNED <b>1/11/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-13-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Jester</b>		ADDRESS <b>901 S. CONKLING ST. BALTO., 24, MD.</b>	
24a. REC'D BY REGISTRAR <b>JAN 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0437

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1624 Providence Road</b>		d. STREET ADDRESS <b>1624 Providence Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>YOUNG</b>		4. DATE OF DEATH Month <b>January</b> Day <b>18,</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1912</b>
9. AGE (In years last birthday) yrs. <b>47</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr. Stock Check Crew</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A. &amp; P. Tea Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Benjamin Charles Young</b>		14. MOTHER'S MAIDEN NAME <b>Mary Edna Sheppard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>212-03-3561</b>	
INFORMANT Address <b>Catherine L. Young, 1624 Providence Rd., Towson</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Peripheral Vascular Disease</b> DUE TO (c) <b>Hypertension; chr. Nephritis; Diabetes</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1946</b> to <b>June 18</b> , 19 <b>60</b> that I last saw the deceased alive on <b>June 18</b> , 19 <b>60</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Tos. A. Sedlack</b>		DATE SIGNED <b>1/20/60</b>	
PHYSICIAN'S NAME (Type) <b>Tos. A. SEDLACK</b>		<b>Towson, 4, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 21, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Catherine L. Young</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0438  
CERTIFICATE OF DEATH

Reg. Dist. No.

00434

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>64 Winter Ave</u>		d. STREET ADDRESS <u>64 Winter Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>John Wesley Young</u>		4. DATE OF DEATH <u>Jan. 26</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1910</u> 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ellicott City Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Ellicott City Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clarence Young</u>		14. MOTHER'S MAIDEN NAME <u>Emma Porter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Morie Young 64 Winters Ave.</u>	
17. INFORMANT <u>Morie Young 64 Winters Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arterio-sclerotic Heart</u> DUE TO <u>Disease</u> 5 yrs - 30 days (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 19th, 1959</u> , to <u>Jan. 26th, 1960</u> , that I last saw the deceased alive on <u>Jan. 26th, 1960</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. F. Maloney M.D.</u>		ADDRESS (Street, city or town, state) <u>57 Winters Lane I/26/60</u>	
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>		DATE SIGNED <u>I/26/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Star</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u>		ADDRESS <u>322 R. Schroeder St.</u>	
24a. REC'D BY REGISTRAR <u>FEB 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





0439

CERTIFICATE OF DEATH

00435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2500 Ambler Court</b>		d. STREET ADDRESS <b>2500 Ambler Court</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>F.</b> Last <b>ZEILER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1921</b>
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Zeiler</b>		14. MOTHER'S MAIDEN NAME <b>Helen Bauer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>Mrs Agnes Zeiler</b>		Address <b>2500 Ambler Court</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Essential Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>5-23-</b> 19 <b>58</b> , to <b>1-12-</b> 19 <b>60</b> , that I last saw the deceased alive on <b>1-12-60</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7001 Warrington Rd</b> DATE SIGNED <b>1-14-60</b> ACTUAL SIGNATURE <b>Eugene F. Nevy</b> M.D. <b>MD</b> PHYSICIAN'S NAME (Type) <b>Eugene F. Nevy M.D. Dundalk Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan 16, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901 Eastern Avenue</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00436

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> 0242 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown 5 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown, Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Glen Falls Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARTIN SHREEVE ZENTZ</i>		4. DATE OF DEATH <i>Jan 23 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 2, 1892</i>
9. AGE (In years last birthday) <i>67 yrs.</i>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <i>Contracting</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Builder</i>	11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>David Grant Zenty.</i>	
14. MOTHER'S MAIDEN NAME <i>Annabelle Martin</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>217-12-8576</i>		17. INFORMANT <i>Martha Zenty - Reisterstown, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>None</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None.</i>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D.D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, RITUAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-26-1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Balto, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leung Byers, Jr. Home</i>		24a. REC'D BY REGISTRAR <i>DATE JAN 25 '60</i>	
ADDRESS <i>8728 Liberty Road, Randallstown, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

Figure 1

1

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
0235 CERTIFICATE OF DEATH

00437

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Relay</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1531 S. Rolling Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY F. ZIEGENFUSS</u> First Middle Last				4. DATE OF DEATH <u>Jan 6 1960</u> Month Day Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/1900</u>	9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Greeting Card Wholesaler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>P.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Milton Ziegenfuss</u>				14. MOTHER'S MAIDEN NAME <u>Sue Tully</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>Marguerite Ziegenfuss</u>			
17. INFORMANT <u>Marguerite Ziegenfuss</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4331 Paroxysmal tachycardia - conduction system</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probable pulmonary embolism</u> DUE TO (c) <u>72 hours - few minutes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>Jan 5 1960</u> , that (I) <del>the</del> last saw the deceased alive on <u>Jan 5 1960</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frederick V. Beidler</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>Jan 6 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK V. BEIDLER</u>				22d. ADDRESS <u>1014 Francis Ave - Balto Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/9/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>				23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Murphy &amp; Son</u> ADDRESS <u>28</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 8 '60</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. H...</u>			



1000 of water was used in the  
process of the treatment of the  
material. The material was  
then dried in a vacuum oven  
at 100°C for 24 hours. The  
dried material was then ground  
to a fine powder. The powder  
was then sieved to remove  
any large particles. The  
powder was then stored in a  
vacuum container until used.